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EDITOR OF THE MONTH

WALTER M. SOLOMON, M.D.
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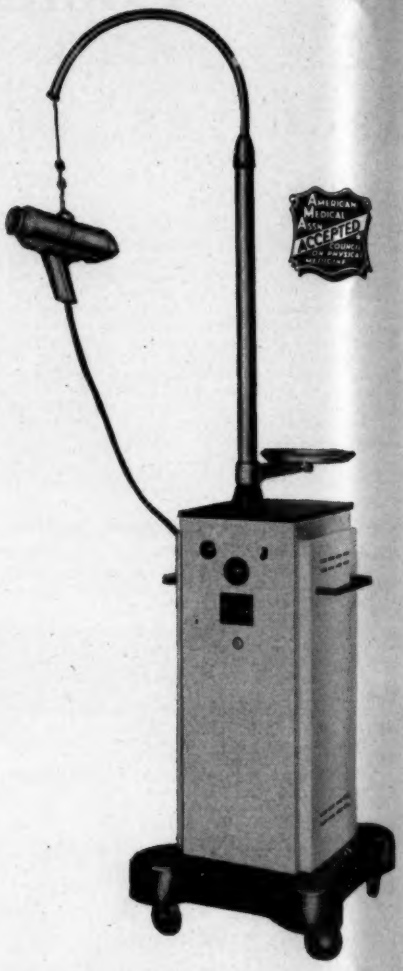

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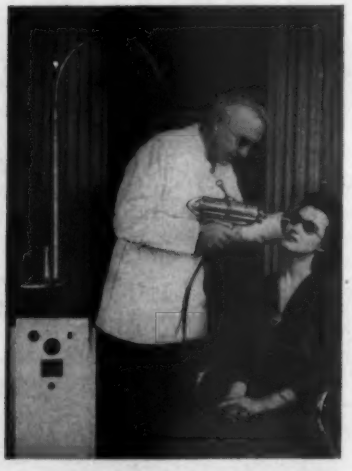

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VIBRATORY THRESHOLD IN NORMAL PERSONS AND POLIOMYELITIS PATIENTS AS AFFECTED BY MOIST HEAT AND INFRA-RED RAYS *

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and

HELEN REISMAN, M.D.

CLEVELAND

It has previously been shown[1] that there is a change in the vibratory threshold in persons who have had poliomyelitis as compared with those who have not had the disease. Such persons are more sensitive, needing less amplitude of vibration to stimulate, and therefore have lowered threshold values.

Cohen and Lindley[2] have shown that changes of muscle tonus induced by exercise and by varied postures are associated inversely with the sensitivity to vibration as measured by its threshold. They pointed out that the opposite relationship was to be expected, since a hypertonic limb, because of greater rigidity, should provide a better conduction medium for vibration than a limb in which the muscles are in a lesser state of tonus. For this reason they do not believe that the explanation for the inverse vibratory sensitivity, i. e. tonus relationship, can be ascribed to mechanical changes. Their explanation is that it may rest in the fact that hypertonic changes are associated physiologically with an increased number and intensity of proprioceptive impulses which, whether induced by exercise or postural variation, act as factors to rival sensitivity to vibration. On the basis of their findings, they subscribe to the view that the central connections over which kinesthetic impulses are carried are also involved in the conduction of vibratory sensibility.

While these investigators suggest that motor impulses compete or "rival" sensory impulses such as vibration, they do not suggest that the reverse is true and that sensory impulses compete or "rival" motor impulses. Their findings do, however, stimulate further interest in sensory threshold in poliomyelitis patients, particularly with reference to the type of heat employed in the treatment of the paresed or paralyzed muscles.

The objective of the experiments reported in this article was to determine whether the vibratory threshold in the sensory skin dermatome area of nerves supplying paralyzed or paresed muscles of poliomyelitis patients was measurably affected by the application of Kenny hot packs or infra-red rays. The previously described pallesthesiometer[3] was used to measure the vibratory response quantitatively. The unit of measurement of this instrument is the amplitude of the vibration, which with the particular vibrator used has been shown to correspond to the square of the voltage applied to the vibrator.

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Leona Kopecny and Sally Mickey assisted in some of the most recent tests.

Sponsored by a grant from the Whitehall Pharmacal Co., New York City.

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Method

Moist heat was applied by means of packs made of hot woolen cloths prepared according to the Kenny technic. For application of infra-red rays, an infra-red treatment lamp, model Z-12, manufactured by the Burdick Corporation, was employed. It was placed approximately 18 inches away from the skin over the paralyzed muscles.

The vibratory test, although a subjective one, has been shown by other neurologic studies to be reliable. Familiarity with the patient's reactions eliminates serious sources of error usually present in most of the subjective tests now in use. The patient cannot misinform the operator because his reactions are continually being observed and his responses are further checked by a silent switch attachment.

In an attempt to obtain a normal threshold of the skin dermatome of the paralyzed muscles, readings were made each morning for three or four consecutive days before any treatment was given. On these days, all treatments except those reported were discontinued to eliminate possible extranous influences. The tests with moist heat and with infra-red rays were made in the same manner but on separate days.

After the pre-test vibratory threshold was determined, the heat was applied. When moist heat was used, hot packs were placed over the area being tested and allowed to remain in position for fifteen minutes. At the end of this time the first set of packs was removed. A second set was applied for another fifteen minutes and removed, after which a threshold reading was immediately taken. Subsequent readings were made every half hour until the threshold had returned to the pre-test level. When infra-red rays were used the lamp was turned on five minutes before exposure of the part tested so that it would radiate at its maximum throughout the exposure.

Care was taken to test the same area each time. A spot no larger than the vibrating disk of the pallesthesiometer was marked with indelible ink. Each threshold reading was made on this small, marked area.

All but one of the patients were tested with both hot packs and infra-red rays. At a later date these series of tests were repeated to determine whether the results were similar, the same procedure being followed.

A third set of tests was then done on the 9 poliomyelitis patients by two persons other than the authors to see whether technicians unfamiliar with our work would obtain the same results.

All normal persons and those affected with poliomyelitis were alert and dependable. All of the patients tested had paresis or paralysis of the muscles of the anterior part of the thigh, including the quadriceps femoris, of at least one leg. The skin area tested was 15 cm. above the middle of the patella on the anterior surface.

Observations

Controls. — Ten normal persons were tested with moist heat and 10 others with infra-red heat. The climatic conditions were not the same, so that there were different original threshold values for those receiving moist heat and for those tested after the application of infra-red rays. However, the results were similar, with no appreciable change after use of heat except in a few instances. The slight elevation of threshold value which occurred in a few persons after application of moist heat disappeared within a half-hour.

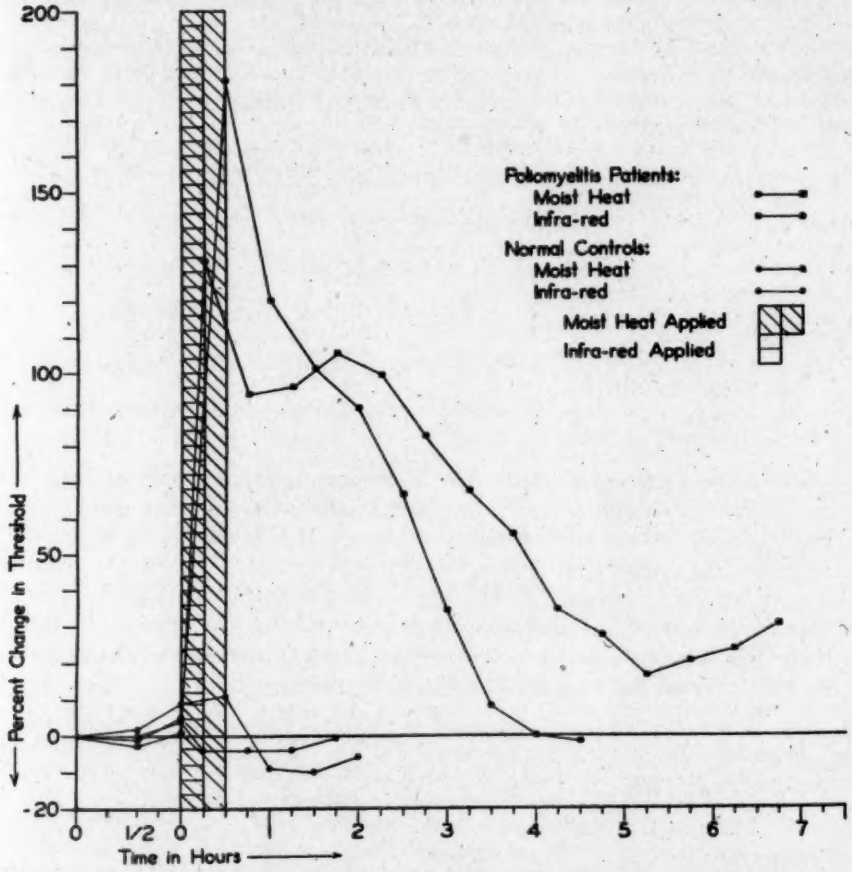
Moist heat:

PATIENT 1 was a 20 year old girl ill with a sore throat. Over the left leg there was an elevation in the threshold of 81 per cent; half an hour later the threshold had returned to the pre-test level. There was no change in the right leg.

PATIENT 2 was a 27 year old woman ill with a sore throat. No change was noted in the threshold reading of either leg.

PATIENT 3 was a 29 year old woman ill with a sore throat. There was an elevation of 5 per cent (within range of technical error) in the left leg, but the threshold reading had returned to the pre-test level in half an hour. There was no change in the threshold reading of the right leg.

PATIENT 4 was a 20 year old girl ill with pharyngitis. There was no change in the vibratory threshold in either thigh.



Changes in the threshold for vibratory sensation of the skin of the left thigh in patients with poliomyelitis as compared with normal persons after application of moist and infra-red heat.

PATIENT 5 was a 19 year old girl ill with parotitis. There was no elevation of vibratory threshold in either leg.

PATIENT 6 was a 20 year old girl ill with parotitis. There was no elevation in the vibratory threshold of either leg.

PATIENT 7 was a 19 year old girl ill with parotitis. There was no change in the vibratory threshold of either leg.

PATIENT 8 was a 21 year old girl ill with pharyngitis due to streptococci. There was no change in the vibratory threshold of either leg.

PATIENT 9 was a 14 year old boy convalescing from scarlet fever. There was no change in the vibratory threshold of either leg.

PATIENT 10 was a 20 year old girl ill with pharyngitis. No vibratory change was noted.

Infra-Red Rays. — The threshold of 3 of the 10 patients tested was elevated by infra-red rays. Two patients showed an elevation on one side and not the other; the third had an elevated threshold in both legs. In all cases the threshold had returned to the pre-test level in half an hour, and it could be concluded that, as a whole, this group showed no alteration in the vibratory threshold.

PATIENT 1 was a 21 year old girl ill with pharyngitis. There was no change in the threshold reading of the left leg. There was an increase of 16 per cent in the right leg, immediately after removal of the infra-red lamp, but within one-half hour the threshold had returned to the pre-test level.

PATIENT 2 was a 22 year old woman convalescing from scarlet fever. There was no increase in the threshold reading of either leg immediately or one-half hour after the infra-red ray lamp was removed.

PATIENT 3 was a 13 year old girl convalescing from scarlet fever. The threshold was elevated 19 per cent in the left leg and returned to the pre-test level in one-half hour. There was no change in the vibratory threshold of the right leg.

PATIENT 4 was a 21 year old girl convalescing from scarlet fever. The threshold of the left leg showed an increase of 43 per cent. It returned to the pre-test level one-half hour after the test. The threshold in the right leg showed an increase of 19 per cent, and after one-half hour had returned to the pre-test level.

PATIENT 5 was a 25 year old woman in the convalescent stage of scarlet fever. There was no change in the threshold reading of either leg immediately or one-half hour after the infra-red ray lamp was removed.

PATIENT 6 was a 19 year old girl ill with pharyngitis. There was no change in the threshold readings.

PATIENT 7 was a 19 year old girl ill with a sore throat. There was no change in the vibratory threshold of either leg.

PATIENT 8 was a 19 year old girl ill with parotitis. No change was noted in the vibratory threshold of either leg.

PATIENT 9 was a 29 year old woman ill with a sore throat. There was no change in the vibratory threshold of either leg.

PATIENT 10 was a 14 year old boy convalescing from scarlet fever. There was no change in the threshold of either leg.

Poliomyelitis Patients Tested After Kenny Hot Packs. — Moist heat caused various degrees of increase in the vibratory threshold of the skin segments of nerves supplying paralyzed muscles; i. e., the patient's skin over those areas became less sensitive and a higher voltage was necessary to cause a reaction. The elevation in the threshold lasted from one-half to three and one-half hours but in all instances returned to the pre-test level not later than three and one-half hours after the packs were removed. In no instance was the test carried on longer than six and one-half hours.

PATIENT 1 (V. H.) showed an elevation in the threshold readings of both sides. The values returned to pre-test levels after three and one-half hours. The increase was 638 per cent over the left thigh, as compared with 213 per cent over the right thigh. Clinically, there was evidence of a greater return of power in the right quadriceps.

PATIENT 2 (M. M.) had an increase in the threshold readings over both thighs; in the left there was an elevation of 108 per cent, with the value returning to the pre-test level at the end of two hours. Over the right thigh there was an elevation of 152 per cent, with a return to the pre-test level in one and one-half hours.

PATIENT 3 (R. A.) showed an elevation over both thighs, 325 per cent in the left and 296 per cent in the right. In three hours the thresholds had returned to the pre-test levels. Clinically, the power in the thighs was poor and about equal.

PATIENT 4 (B. B.) had an elevation over both thighs, 85 per cent in the left and 150 per cent in the right. The threshold over the left remained elevated for one hour and that over the right for two and one-half hours. Clinically, the power in the thighs was poor and about equal.

PATIENT 5 (E. G.) showed an increase in the threshold reading over both thighs. Over the left it was 134 per cent, with a return to the pre-test level in one-half hour, and over the right there was an increase of 50 per cent, with a return to the pre-test level only after one and one-half hours. Although clinically there was some return of muscle power in both thighs, it was slightly greater in the left.

PATIENT 6 (T. H.) was tested with infra-red rays only because of a hypersensitivity to the wool used for the hot packs.

PATIENT 7 (A. R.) showed a 63 per cent increase in the threshold reading only over the right thigh, the increase lasting one-half hour. This patient had no actual paralysis, merely paresis.

PATIENT 8 (D. C.) had elevations of 83 and 59 per cent, each of which lasted for three hours. Clinically, the muscle efficiency of the two thighs was about equally affected.

PATIENT 9 (D. C.) had an increase in the threshold reading over the left thigh of 65

per cent which lasted for two and one-half hours. The threshold over the right thigh, however, showed an increase of only 20 per cent and returned to the pre-test level at the end of one hour. The muscles of the right thigh had five times more power than those of the left.

Poliomyelitis Patients Tested After Exposure to Infra-Red Rays. —

PATIENT 1 (V. H.) showed an increase of 382 per cent in the threshold of the left leg, which at the end of six hours had not returned to the pre-test level. The right leg, however, showed an increase of only 81 per cent and the threshold had returned to the pre-test level at the end of five hours. The right thigh muscles were stronger.

PATIENT 2 (M. M.) had an increase for the left and the right thigh of 266 per cent and 212 per cent, respectively. Neither threshold had returned to the pre-test level at the end of six and one-half hours. The patient was severely paralyzed in both legs.

PATIENT 3 (R. A.) showed an elevation in threshold of 170 per cent for the left thigh area and of 127 per cent for the right. Neither value had returned to the pre-test level at the end of six hours. There was severe involvement of both legs.

PATIENT 4 (B. B.) showed an increase of 76 per cent in the first test made over the left thigh area. The value returned to the pre-test level in three and one-half hours. The right thigh area showed an increase of 85 per cent, and after five and one-half hours the threshold had not returned to the pre-test level. A second test showed a threshold elevation of 131 per cent over the left thigh area and of 21 per cent over the right. Neither value had returned to the pre-test level at the end of five and one-half hours.

PATIENT 5 (E. G.) had an increase in the threshold reading over the left thigh area of 100 per cent, but the value had returned to the pre-test level at the end of six hours. The threshold over the right thigh increased 341 per cent and had not returned to the pre-test level at the end of five and one-half hours.

PATIENT 6 (T. H.) showed an increase of 588 per cent in the threshold over the left thigh area, and the value had not reached the pre-test level at the end of five and one-half hours. The threshold for the right thigh area increased 109 per cent and did not return to the pre-test level for one and one-half hours. The left thigh was the weaker of the two.

PATIENT 7 (A. R.) showed an increase in threshold of 43 per cent in the first test over the left thigh area. The threshold reached the pre-test level at the end of one and one-half hours. The right thigh area showed an increase in threshold of 40 per cent, but the value did not reach the pre-test level until two and one-half hours later. The readings obtained in a second test showed elevations of 31 and 16 per cent, respectively. Both threshold readings returned to their pre-test levels at the end of one and one-half hours.

PATIENT 8 (D. C.) showed an elevation of 93 per cent for the left thigh area, and of 94 per cent for the right. Neither threshold returned to the pre-test level until five and one-half hours later.

PATIENT 9 (D. C.) had an elevation of 62 per cent over the left thigh area and of 27 per cent over the right. At the end of five and one-half hours both thresholds had returned to the pre-test level.

Comment

The application of moist heat as well as use of infra-red rays caused two types of response: (1) there was an elevation of the vibratory threshold, i. e., sensation became less acute, and (2) this elevation persisted for some time. Both the elevation in the vibratory threshold and its persistence varied in degree. When the rays could be directed and tested in one plane or one spot, infra-red rays consistently caused an elevation in threshold of greater duration than did moist heat. No accurate determination, however, could be made to ascertain the comparative threshold-raising ability of each type of heat because of the variable factors unavoidably introduced. The actual percentages of elevation have been computed, but these figures were not used as a basis for comparison, since readings were not always consistent. The duration of the elevation, on the other hand, seemed inferentially to be a reliable comparative index of relative muscle power.

With the use of hot moist packs, it is nearly impossible to keep the temperature constant in every case from day to day. The patients' individual tolerance to heat may vary greatly. Also, the packs may contain more water at one time than at another, this causing the rate of cooling after ap-

plication to vary. In addition, the initial temperature of each set of hot packs may differ slightly.

With infra-red rays there is less opportunity for variations in results of the tests. There are, however, differences in the amount of heat absorbed by each person owing to differences in pigmentation, the contour of the body, the amount of perspiration, the amount of adipose tissue and the fact that only one exposed plane surface can be used.

In view of the possibilities for variation in the amount of heat actually absorbed, it is obvious that any quantitative study of the effect of the two types of heat, except in a general way, cannot be accurate. Nevertheless, the general effects of hot moist packs and of infra-red rays on the vibratory threshold can be estimated by comparing the duration of the change in the threshold. Notwithstanding variable factors, it is felt that the difference in the duration of the elevation caused by moist heat and by infra-red rays was great enough to be significant.

It is, moreover, suggested that the threshold tests demonstrated some correlation between the degree of paralysis and the amount and duration of the elevation of the vibratory threshold.

Sometimes there was a difference in the duration of elevation of vibratory threshold between the left and the right leg, particularly in postpoliomyelitis patients. In comparing these differences with the clinical picture, it can be shown that the muscle with more recovered muscle power had a more rapid return of the vibratory threshold of the skin dermatome to the original level. In other words, the more efficient a muscle, the shorter was the duration of increased threshold.

It will be further noted that in none of the control tests, either with infra-red rays or with moist heat, was there an appreciable elevation in the thresholds. In the few instances in which there was some elevation, its duration was not more than one-half hour. From a practical therapeutic standpoint, especially when many muscles are involved and when many planes need exposure simultaneously, the use of hot packs rather than of infra-red rays is indicated.

Summary

The vibratory threshold of muscles affected by poliomyelitis was elevated, i. e., sensation became less acute, by both infra-red rays and moist hot packs.

The elevation of the threshold with infra-red rays lasted longer than the elevation provoked by moist heat. Nevertheless use of moist heat seems more practical if multiple muscles and hence multiple planes are to be treated.

The elevations of varying degrees depended on the amount of heat absorbed and on several varying factors.

There was no appreciable change in the threshold of the control patients who had neither paralysis nor paresis.

It was suggested that the length of time during which the threshold remained elevated was associated with the amount of paralysis of the muscle tested.

MODERN PHYSIOLOGIC CONCEPTS OF SPINAL CORD FUNCTION AND POLIOMYELITIS *

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Any discussion of the physiology of the observed symptoms in poliomyelitis has to take into account the histologic lesions as observed in that disease. Contrary to the belief of many physicians that the focal lesions caused by the virus are restricted to the spinal cord, it is a well established fact that cases with only lesions of the spinal cord are very rare, if existent at all. The typical lesions are found, besides in the spinal cord, in the cerebral cortex, basal ganglia, thalamic and hypothalamic nuclei, midbrain, pons, vestibular and associated cerebellar centers, and medulla oblongata.[1] Spielmeyer[2] emphasized in 1932 that the lesions in the central nervous system are found mostly but not exclusively in the motor systems.

Although the focal lesions are scattered through the whole central nervous system, the highest density of lesions is found, as a rule, in the spinal cord. The anterior horn cells are by far the largest ganglion cells in the spinal cord, and therefore small degenerative occurrences can be detected in them rather easily. However, all recent investigators agree with Spielmeyer[2] that only in few anatomic parts of the gray matter of the spinal cord will poliomyelitis never be found. Those regions containing the cell bodies of the internuncial neurons are regarded today as the most commonly affected areas of the cord in human[3] and in animal poliomyelitis.[4]

Some of the earlier damage to neurons is apparently reversible, as pointed out by Baker.[5] However, how far the often remarkable recovery from an extensive paralysis is due to regaining of normal functions by once damaged cells, to regaining or normal function of units temporarily blocked by neighboring hyperemia, edema or interstitial cellular infiltration or to some functional switching of pathway connections in the spinal cord, is still beyond direct analysis.

Attempts have been made by various investigators to correlate site and extent of lesions with the symptoms observed. All agree more or less with the statement of Schwalbe[6] made in 1902 in a summary of all human cases reported at that time, that at autopsy often more damage is found than expected from the clinical symptoms. Recently this has been confirmed again by Hall, Van Wart and Courville[7] and by Elliot.[8] For animal poliomyelitis, heavy damage at autopsy with relatively few signs through life, and even maximal histologic changes in completely nonparalytic cases, have been reported.[9] This might be explained with the basic concept and all organ systems function under a large margin of safety.

Of highest theoretic and practical importance is the question whether the skeletal muscles themselves are directly affected by the poliomyelitis

* Read at the Eastern Sectional Meeting of the American Congress of Physical Medicine, Washington, D. C., April 13, 1946.

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infection. One should expect that the general claim of Sister Kenny[10] that muscles are more affected by the disease than previously recognized would have stimulated such investigations. Up to now, however, results of such research have been reported by only two independent groups of investigators. Hassin[11] described the autopsy findings in a patient who died seventy-two hours after onset of poliomyelitis with a symptom complex which can be classified as Landry's paralysis. Besides a myocarditis as described by others,[12] there was found in many skeletal muscles, especially in the intercostals, a parenchymatous swelling and disruption of muscle fibers and also inflammatory focal and diffuse infiltration. Carey[13] has asserted that in early human and animal poliomyelitis the motor end plates are partly shrunken or even destroyed and that from the motor end plates degeneration advances "centripetally." He also described hyperemia and perivascular infiltration in weakened, but not paralyzed, muscles. In evaluating these findings, one must keep in mind that after section of the motor nerve the first muscle changes detectable by histologic methods occur only after five to seven days and that they are not of an inflammatory nature. Therefore, it is not likely—if such early changes really exist in poliomyelitis—that they are secondary to damage of the anterior horn cells.

If one attempts to correlate, as far as possible, site and extent of the histologic lesions of the nervous system with the signs and symptoms observed, one needs a fairly clear understanding of the normal mode of functioning of the spinal cord. Unfortunately, the concept of the spinal cord which a present day physician acquired during his student years is no longer valid. In the simple scheme of the spinal cord prevalent still a few years ago, the pyramidal pathways and the extrapyramidal ones made direct contact with the anterior horn cells, and in consequence the general belief was that spinal damage has to result in paralysis of reflex and volitional movements to the same extent. In the last eight years, especially through the work of Lorente de Nó,[14] of Lloyd[15] and of Renshaw,[16] who recorded the action currents of individual intraspinal neurons, a much more complicated picture of the spinal cord function is visualized. Only for myostatic or proprioceptor reflexes, a simple two neuron arc exists, in which a single impulse can pass directly to the anterior horn cells. In all other activities, complicated internuncial circuits, spread through several segments of the spinal cord, are involved. If a single stimulus is applied to a pyramidal fiber in the neck, repetitive impulses reach the anterior horn cells. Under normal conditions, only such a series of impulses can excite an anterior horn cell through the pyramidal or extrapyramidal system or in coordinated reflex activity of a nonmyostatic nature. The pool of internuncial neurons is of paramount importance in the distribution of excitation reaching the spinal cord. Premotor internuncial neuron chains play a different role according to the number of links involved. If the number is small, activation of the chain results in inhibition; but if the number of links is large, sustained facilitation results.[14] The internuncial pool in its normal functional state maintains reciprocal innervation of antagonistic muscles. According to this modern view of the physiologists, direct synaptic contact between endings of the pyramidal tract and the anterior horn cells are of minor importance. This is in agreement with degeneration studies, which have shown that 90 per

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cent of the end branches of the pyramidal fibers terminate upon internuncial neurons.[17] Probably the same is true for the extrapyramidal pathways which play a role of importance in the execution of skilled acts.

Russian investigators, using quite different methods, reached very similar conclusions. Beritoff[18] demonstrated that single afferent impulses are not able to excite the internuncial pool with its coordinating activity but can excite the anterior horn cells directly. His pupil Gedavini[19] showed that if several impulses reach the internuncial pool the latter is activated and its coordinating activity gets the upper hand over the directly influenced motor neurons, thus enforcing coordination with reciprocal innervation of agonists and antagonists.

Experimental evidence presented by Lorente de Nó[14] and by Renshaw[16b] indicates the existence and importance of recurrent collaterals of the axon cylinder of the anterior horn cells. These collaterals, not yet demonstrated beyond doubt by the histologists, probably terminate mainly on internuncial cells involved in the inhibition of the antagonistic anterior horn cells.

According to van Harreveld,[20] the internuncial neurons are more sensitive to anoxia than are the anterior horn cells, and often anoxia, after damage only to the internuncials, produces incoordination and increased tonic reactions. After various toxic damages to the internuncials, synchronization of impulses in antagonist muscles occurs, disrupting normal reciprocal innervation, as shown by Bremer.[21] Kabat and Knapp[22] produced by temporary ischemia of the spinal cord of dogs, which affects mainly the internuncials, muscle spasm maintained for months and of the same nature as that found in human poliomyelitis.

Although some of the concepts thus far presented are too new to have influenced to any appreciable extent the clinician's views of the pathologic physiology of poliomyelitis, it is instructive to attempt to reconcile recently stressed symptom complexes with present knowledge of the physiology of the central nervous system and with the site of the focal lesions.

Much interest has been focused recently on the mechanism of so-called "spasm." This physical sign had not been overlooked completely in the past, but it was explained as a manifestation of the meningitis supposed to be associated more or less regularly with poliomyelitis. A number of investigators have studied this phenomenon with the action current method.[23] All agree that true spasm — namely, a weak tetanic contraction — is frequently found. There is a good deal of discussion whether more spasms of this type are found in weakened muscles or in their antagonists. There is no doubt that they can be present in apparently not otherwise affected muscles and that they are absent in muscles of which all anterior horn cells are destroyed. During volitional activity, the action currents of weakened muscles have a lower potential than normal muscles, and the potentials can be used for grading muscle activity.[24] Although volitional activity may be weak in affected muscles, their response to stretch is often much greater than in normal muscles. Watkins and others[25] have pointed out that this

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25. Schwartz, R. P.; Bouman, H. D., and Smith, W. K.: J. A. M. A. **126**:695, 1944. Watkins, Brazier and Schwab.[23f] Watkins.[23g] Watkins and Brazier.[23h] Hansson, Troedsson and Schwartzkopf.[24]

increased sensitivity of the stretch reflex mechanism does not correspond always with the severity of the spasm observed clinically but that this increased sensitivity decreases, as a rule, with improvement of the patients. Schwartz and Bouman[23c] reported cases in which at least the electrical response to stretch was much larger than that in any voluntary movement of that muscle. With the action current method, it was further demonstrated that in some cases of poliomyelitis complete disruption of reciprocal innervation occurs.[23c-d]

Buchthal and Høncke[26] investigated carefully this disturbance of reciprocal innervation and found that in poliomyelitis not only the tendency exists to synchronize activity of antagonistic muscles but also in single muscles the tendency to synchronize the activity of the individual motor units is much higher than in normal muscles. They stated that the less the increased synchronization during the acute state, the better the prognosis for complete recovery of functions.

Spinal anesthesia does not completely abolish spasm in chronic cases.[22] This indicates not only that at least at a later stage the mechanism of the spasm is a central one but that either contracture has developed or that the spasm is partly caused by excitations originating in the muscle fibers themselves. It is well known that isolated frog muscles briefly soaked in isotonic saline solution fall into rhythmic activity when touched or stretched.[27] Altenburger[28] reported that even in normal isolated frog muscles a weak stretch reaction can be elicited. Thus it may possibly be that spasm in poliomyelitis has a peripheral component because of changes in the muscle making the muscle fibers themselves abnormally sensitive to touch and stretch. Such a combination of central and peripheral mechanisms for a spastic condition is well known to exist in muscle cramps occurring during or after fatiguing exercise.[29]

If one is willing to accept, even for the early stage, partly a peripheral mechanism for the spasms, they might be explained also by assuming that in affected muscles a normally present but unimportant mechanism is extremely exaggerated. As shown by Lloyd[30] and by Lorente de Nó,[31] conduction of impulses through the intermuscular nerve and discharges of the motor end plates produces stimulation of adjacent fibers. Feng and Li[32] found that this mechanism is much exaggerated after poisoning of the muscles with various drugs and is partly responsible for the drug contractures observed. Granit and co-workers[33] demonstrated recently that such excitation of adjacent fibers can occur in any peripheral nerve slightly damaged by pressure or other causes. They emphasized the probable importance of this mechanism for "referred pain" and "causalgic symptoms." It is important to point out that if such a spasm mechanism due to primary damage to the muscles in poliomyelitis should be established in the future one is confronted with a situation incompatible with one's knowledge of physiology. For the existence of a peripheral factor, or at least for the existence of a peripheral eliciting factor of a reflex mechanism, speaks the fact that Kenny's hot fomentations not only diminish pain but also diminish the spasms.

However, not only spinal cord lesions and alterations of intramuscular nerves and of the muscles themselves might be causal factors for spasm but

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33. (*a*) Granit, R.; Leksell, L., and Skoglund, C. R.: Brain 67:125, 1944. (*b*) Bodian, D.: Proc. Soc. Exper. Biol. & Med. 61:170, 1946.

also central nervous system lesions above the spinal cord can be involved in the production of spasmlike conditions. Bodian[33b] observed that in monkeys infected by the nasal route with poliomyelitis virus definite spasticity of the limbs occurred in the acute stage. At autopsy no lesions and virus activity could be found in the cord, but severe lesions existed in the midbrain and the hindbrain, affecting the extrapyramidal pathways.

Of all the new concepts brought into the discussion of poliomyelitis by the activity of Sister Kenny, "spasm" is the one which has found general recognition as a true physical sign often present in the disease. Much less recognition has been given to her concept of "incoordination." In the discussion of spasm, we reviewed the experimental evidence that, at least in some patients, there exists without doubt a disruption of reciprocal innervation. Such an abnormality in the transmission of impulses through the internuncial pool can result in nothing other than incoordination. Furthermore, it is well known that in painful peripheral conditions, volitional and reflex coordination in otherwise normal persons can be altered extensively.[34]

"Substitution," which has long been recognized as occurring frequently in patients with poliomyelitis, is well known as a compensation in various types of paralysis affecting isolated muscles or muscle groups. Substitution in poliomyelitis may ultimately be a desirable form of compensation. In the early stages of the disease, however, as long as the function of affected muscles may improve, substitution enhances by disuse the further deterioration of the affected muscles.

The Kenny concept with which the medical profession found utmost fault is "alienation" of the muscles. She says that "loss of ability to contract muscles is due to functional dissociation from the nervous system."[10] Although nobody can deny that anterior horn cells are often destroyed in poliomyelitis, we must consider seriously whether there exists a state in which the anterior horn cells can still function but cannot be thrown into activity by volitional efforts. There exists an old experimental observation by Heinbecker[35] that in monkeys with poliomyelitis a state exists in which the motor horn cell and its axon-cylinder is still functioning but in which stimulation of the pyramidal tract is not able to produce muscle activity. The experience mentioned before, that spasm exaggerated by stretch is often stronger than volitional movements,[23f] can be explained only by the assumption that a certain number of motor neurons can be activated reflexly but not through pyramidal or extrapyramidal tracts. All this can be explained, as discussed under the normal physiology of the spinal cord, by damage to the internuncial pool. Minkler[3b] published histologic evidence supporting such an assumption. In poliomyelitis, a large number of degenerated synaptic endings are found around normal anterior horn cells. There is every reason to assume that the degenerated endings are those of internuncial neurons, and the normal ones are mainly those of afferent fibers for stretch reflexes. Thus, alienation, as defined here, is at least explainable, and is not contrary to physiologic knowledge.

Up to now, I have considered alienation as due to damage of the internuncial neurons. But there exists the possibility of another mechanism for such a symptom — namely, by mild alterations in the anterior horn cells proper. Campbell[36] demonstrated that during the temporary partial degeneration occurring in the anterior horn cell after peripheral section of its axon-cylinder, the motor neuron can still be activated by stimulation of dorsal

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root fibers normally involved in cutaneous reflexes but cannot be activated any longer by fibers normally eliciting stretch reflex. Alienation is not such a new sign, as one would believe if reading only the newer literature about poliomyelitis. Every one who has worked extensively with experimental nerve sutures is familiar with the fact that occasionally in an animal the reinnervated muscles can be activated by stimulating the regenerated motor nerve but that they cannot be used in either reflex or voluntary movements. Barron[37] observed this phenomenon in nearly 50 per cent of his animals operated on. For man, it often has been reported that activation by nerve stimulation is possible days or even weeks before reflex or volitional movements occur after nerve suture.[38] Confirming older clinical reports of long-lasting pseudoparalysis of this type,[39] Ufland described recently the development of such a radialis paralysis in a Russian soldier.

As an argument against the possibility of the existence of alienation, it has been pointed out that the muscles involved are all severely atrophied and that therefore the motor neurons must be destroyed. Such an argument is fallacious. It has been repeatedly demonstrated that after upper neuron lesions with no damage to the motor neuron, disuse atrophy progresses at nearly the same rate as atrophy after nerve section until the flaccid paralysis changes to a spastic paralysis.[40]

The problems of muscle function in poliomyelitis are further complicated by the fact that as a rule not all motor units of an anatomic muscle are involved in the same way and to the same extent by all the possible mechanisms outlined. Nevertheless, present knowledge of the physiology of the central nervous system and of the nature of distribution of the lesions in poliomyelitis permits one to visualize some of the probable mechanisms involved in the causation of the observed symptoms. Since the internuncial neurons, which are of such importance according to the newer physiologic concepts, are not always at the same spinal cord levels as the anterior horn cells connected with the affected muscles, it becomes understandable why often the level of damage in the spinal cord does not correspond to the level from which the motor nerves originate.

Discussion

Dr. R. H. Todd (Washington, D. C.): Dr. Fischer has clearly presented the most acceptable concepts of the physiology of symptoms in poliomyelitis.

The role of the internuncial neurons in the symptomatology of polio is certainly the important one and the involvement of the anterior horn cells is secondary. It is difficult to imagine that the concepts of poliomyelitis remained unchallenged so long when so much was obviously wrong.

The credit for this revolutionary move obviously belongs to Sister Kenny, who was the first to create doubt in our text-book theories.

The involvement of other parts of the body than the nervous system seems probable in view of work described by Dr. Fischer. Evidence is accumulating to defend those who believe that the muscles, the heart and possibly other organs may be damaged directly by the virus or by a product of the infection.

Dr. Fischer was kind to the medical profession when he said muscle spasm was not completely overlooked in the past. A stiff neck, back and positive Kernig sign were always mentioned as manifestations of meningeal irritation, but no one explained why they did not clear up when the disease subsided. Muscle spasm of the gastrocnemii was never mentioned, they were always overactive normal muscle contracting against paralyzed antagonists.

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CAUSALGIA *

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Causalgia is a syndrome consisting of burning pain, vasomotor disturbances and trophic changes of the skin, bones and joints. It occurs mainly on hands and fingers, less frequently on feet and toes and rarely if ever on more proximal parts of the extremities. Supposedly it follows minor injuries to a peripheral nerve—i. e., the median or the sciatic. If the nerve is completely severed causalgia does not appear. It is not necessarily the result of a direct trauma. A Colles fracture or a sprained wrist may be the cause. The pain may be moderate or very severe and completely incapacitating. There is frequently tenderness to slight touch or friction. Even exposure to a draft can be painful. Sensory changes, however, do not follow any definite pattern, or they may be absent. The skin of the involved part—fingers and hand, for example, is usually of a bright red or more purplish color. There is puffiness or frank edema. The skin feels hot. On exposure to heat, pain and edema frequently increase. Cold applications sometimes relieve the pain. Sometimes, especially if intensive, they produce a livid discoloration and coldness of the fingers which is maintained for hours, and there may be more pain. Fairly early in causalgia the skin becomes glossy, thin, like cigaret paper, and smooth. The nails are riffled, curved and dull. In some cases the involved skin shows excessive perspiration. Four to six weeks after onset, x-ray reveals in many cases a mottled osteoporosis, especially of epiphyses and carpal or tarsal bones—Sudeck's atrophy. There may also develop a narrowing of interphalangeal joint spaces. The fingers are usually kept in slight flexion. Neither complete extension nor full flexion can be carried out actively. Forced motion is extremely painful. Atrophy of intrinsic muscles is manifest unless hidden by edema. Even more proximal muscle groups may show wasting. At a late stage the diseased hand or foot may become cold and of a bluish color, while pain, tenderness, edema and sweating persist.

Although many cases of causalgia have been carefully observed, the syndrome is very poorly understood. Measurement of skin temperatures, oscillometry and plethysmography have shown an increased blood flow of varying degree. This increased circulation has been explained as a result of antidromic vasodilator reflexes arising at the site of injury or as produced by a sympathetic vasodilator mechanism (de Takats).[1] Lewis[2] is inclined to assume a mechanism similar to that in erythralgia—namely, the local release of pain (and vasodilator?) substances. He also considers a similarity between causalgia and herpes zoster.

Some observers separate Sudeck's atrophy from causalgia; others do not. In Sudeck's atrophy the appearance of mottled osteoporosis is considered characteristic. Undoubtedly many cases of causalgia in which bone changes are not mentioned would have shown the osteoporosis if x-rays would have been taken.

Many patients with causalgia have compensation interests or other psychologic difficulties.

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* Read at the Eastern Sectional Meeting of the American Congress of Physical Medicine, Washington, D. C., April 13, 1946.

1. Miller, D. S., and de Takats, G.: Posttraumatic Dystrophy of Extremities; Sudeck's Atrophy, Surg., Gynec. & Obstet. 75:558 (Nov.) 1942.
2. Lewis, T.: Pain, New York, 1942, p. 90.

In my experience the syndrome of burning pain in fingers and toes, with excess circulation, puffiness and trophic changes, occurs not uncommonly in milder degrees. In such mild cases there is frequently no history of trauma. The pain appears especially at night and forces the patient to get up and swing the hands up and down or put them under cold water. Trophic changes may be minimal, limited to the nails or the skin around the nails. These cases will usually be diagnosed as erythralgia or erythromelalgia. I have also seen severe cases without a known preceding trauma. During the last year I have observed 2 patients with chronic lymphatic leukemia who developed herpes zoster on their left upper extremity, extending on to the hand. Both showed as sequelae of the herpes, a syndrome like causalgia. The extreme cases with complete invalidism may only occur as typical post-traumatic causalgia.

It appears doubtful to me whether one should separate post-traumatic cases from those without a history of injury and designate only those of the first group as causalgia and those of the latter as erythralgia or vasomotor neurosis.

There is obviously no sharp delimitation in symptoms and signs. Furthermore, the mechanism by which trauma produces the syndrome is obscure. Frequently the type of injury, its relative mildness and the persistence of causalgia after the apparent complete repair of the injury militate against a direct relationship between trauma and the syndrome.

I wish to report briefly 1 mild case, 1 severe case without trauma, 2 typical cases after injury and 2 postherpetic cases.

CASE 1. — A white man 38 years old, a butcher by trade, was first seen in September, 1944. He complained of burning pain of the left third and fourth fingers, of from four to five months' duration, present only at night. The pain, although more annoying than severe, woke him up regularly and made him get out of bed and walk around for a while. During the day there was a sensation of numbness in the same two fingers. Physical examination showed the fingers of the left hand to be of dusky color and of a temperature between 90 and 92 F. at a room temperature of 72 F. The right fingers were 2 to 3 degrees lower. There was a diminuation of pinprick sensation on the left third and fourth finger pads. These fingers appeared at times puffy, and sometimes the skin was more wrinkled than that of other digits. Oscillometric readings were equal and normal on the two forearms. Results of systemic and neurologic examination were negative. The pain persisted until July, 1945 and then disappeared. In March, 1946 the patient had no pain but showed an abnormal wrinkling of the skin on the palmar side of the fingers of both hands. There was no history and no evidence of trauma. The only possible external cause could have been the handling of cold meat. The patient is a highstrung, somewhat hypochondric person.

CASE 2. — A white male tailor, 54 years old, was examined the first time in September, 1940, when he complained of "severe painful heat" in his right hand and forearm of five months' duration, "pins and needles" in the fingers and swelling and weakness of the hand and fingers. The right hand and fingers showed a firm edema and were of dusky red color. There was at times profuse perspiration on the right side while the left hand was dry. The skin temperatures of the right palm was 95 F. and that of the left was 94 F. at a room temperature of 71 F. Immersion of both legs in water of 65 F. for thirty minutes did not reduce the temperature on either hand. Immersion of both hands in water at 65 and of 108 F. had no influence upon the pain. Oscillometric readings were equal and normal on the two forearms. The patient was unable to bend or extend the fingers fully, and forced motion was painful. X-rays showed a mild degree of mottled osteoporosis. There was also some atrophy of the skin. Neurologic examination was essentially negative. The condition remained unchanged for several months. Then an almost complete remission occurred, lasting from June, 1941 until September, 1941, when pain, swelling and heat returned. Several relapses and remissions were observed afterward. The skin color changed to bluish red and the fingers were cold, but swelling and pain persisted with intermissions during 1942 and 1943. In 1944 the whole syndrome disappeared, and in 1945 the patient returned to work. There was no history or evidence of trauma. No obvious signs of psychic imbalance were observed.

CASE 3. — A white female physician, 57 years old, contracted a right subdeltoid bursitis. In October, 1945 the bursa was incised, a calcium deposit removed and a plaster cast applied.

Pressure pain appeared in the area of the olecranon and the proximal part of the flexor side of the forearm. On the sixth day the cast was removed. In the meantime weakness and pain appeared in the third and fourth fingers. Because the shoulder was now "frozen" an attempt at forced mobilization was made under anesthesia. Thereafter, severe pain, itching and burning became prominent in all fingers. The fingers and the right hand were swollen and warmer than the left. The skin was of bright red color, thin and glossy. The nails showed a rough curved surface. There was incomplete extension and markedly limited flexion of interphalangeal joints and atrophy of intrinsic muscles. X-ray showed marked mottled osteoporosis. Neurologic examination was essentially negative. A gradual, although incomplete, regression of all these findings has taken place during the last three months.

Case 4. — A 70 year old white woman cut the flexor side of her left wrist as a child. A little growth developed on that side without causing discomfort. In 1944 the tumor was diagnosed as a ganglion, and an attempt was made to remove it. It turned out to be a neuroma of the median nerve. Severe burning pain in the fingers and the palm of the hand followed. There was also swelling, redness, heat and weakness of the fingers and an inability to flex the thumb.

In summer 1945 a second operation was performed and adhesions removed. The pain was greatly relieved. In October, 1945 the patient showed puffy, hot fingers and a glossy atrophic skin. There was hypesthesia of the pads of the second and third fingers and the radial side of the fourth finger. A slight touch, especially if unexpected, on the thenar eminence, the wrist and the plantar side of the thumb caused severe pain. Active motion in the interphalangeal joints of the thumb and the third finger was impossible; passive motion, very painful. Flexion of the remaining fingers was incomplete. On exposure to cold the skin became bluish red and pain increased. X-ray showed patchy osteoporosis. Over a period of two months pain decreased and motion improved, but the trophic and vascular changes remained unchanged.

Case 5. — A white male architect, 62 years old, suffering from chronic lymphatic leukemia, in February, 1945 developed herpes zoster on his left upper extremity which extended down to the wrist. Some of the lesions became gangrenous and healed with scars. He was seen in June, 1945, when he still complained of severe burning pain in the hand and fingers. The skin of the palm and the lower third of the forearm was painful to slight touch, and the friction of the sleeve on the wrist was unbearable. The patient had his hand and forearm covered with a silk stocking. The fingers and hand were red and puffy, the skin atrophic and glossy and the nails atrophic. The temperature of the left third finger was 2 degrees higher than that of the right. Oscillometric readings were 2 on the left wrist and 1½ on the right; 3 on the left forearm and 2 on the right. There was hyperesthesia on the left thenar eminence and from there extending to the lower third of the forearm. Muscle power of the whole left upper extremity was diminishd. The shoulder joint and the finger joints showed considerable limitation of motion. Mottled bone atrophy was present on x-ray. Motion in the fingers and the shoulder increased slowly; pain and tenderness became milder, and the patient returned to limited activity by October, 1945.

Case 6. —A 60 year old woman with chronic lymphatic leukemia developed herpes zoster on her left upper extremity in June, 1944. A few lesions appeared on the second and third fingers. When she was examined in October, 1944 there were still a few crusts on the base of the third finger. The finger was swollen. The remaining fingers were red and hot. There was burning pain and tenderness on touch of the palm and fingers. Atrophy of skin and nails was marked, and there was considerable patchy bone atrophy. X-ray also revealed narrowing of interphalangeal joints. The fingers were fixed in extension, and forced motion was very painful. The intrinsic muscles were markedly atrophic. Neurologic examination was negative. The condition remained almost stationary during a year of observation.

I am fully aware of the fact that cases 1 and 2 can be classified as vasomotor neurosis and cases 5 and 6 as postherpetic neuralgia. However, these cases would undoubtedly be designated as causalgia or Sudeck's atrophy if their symptoms and signs were post-traumatic. It appears to me that the syndrome of causalgia will lend itself better to study if trauma is not considered its indispensible and only responsible etiologic factor. Then the highly hypothetical explanations for the mechanism of vasodilatation and pain become untenable. It is obvious that the mechanism of excessive blood flow through the digits, hands and feet and its relation to burning pain need complete new investigation. The problem is still more confused by the therapeutic experience that a sympathetic block frequently relieves the pain although it may increase the blood flow to the extremity.

In the therapy of the severe posttraumatic causalgia surgical measures are apparently most successful. I shall mention these only briefly. An immediate and most careful repair of the traumatic lesion is imperative. It may consist of the removal of a projectile or of perineural adhesions, or it may be the proper immobilization of an injured wrist. The pain seems to respond best to a sympathetic block. Repeated paravertebral procaine injections and sympathectomies have resulted in relief of pain. Periarterial stripping has had favorable reports in France.[3]

Physical therapy has obviously no place in the treatment of the severe acute case. It is of utmost importance for milder cases in which the pain can be controlled with the usual sedatives and there is a tendency to regression. It is also of greatest importance for the rehabilitation of the patient after sympathectomy. Limitation of motion of finger joints, muscle atrophy and vascular changes benefit from physical measures. Exercises, effleurage, alternate bath, heat and histamine ion transfer may prove of value. However, any of these applications may cause more pain and actual harm. It needs a very careful evaluation of symptoms and signs of the individual case and a very close observation during the treatment if physical therapy in causalgia is to be successful and safe.

Summary and Conclusion

An attempt has been made to include nontraumatic cases in the syndrome of causalgia. Six case reports were presented, and the therapy was briefly discussed. It is hoped that the study of the poorly understood syndrome will be stimulated by this presentation.

Discussion

Col. V. G. Urse (Washington, D. C.): There is little to add to the presentation of Dr. Harpuder. The condition has been known descriptively since the time of Wier Mitchell. Periods of war tend to produce an increase in the incidence of the disorder, but as pointed out, the condition can and does occur frequently in civilian life.

Dr. Harpuder points out the difference in the degree to which causalgic symptoms may be present and calls attention to the fact that causalgia is a symptom complex. While the classical picture presents the factor of trauma, one should not lose sight of the fact that this is only one part of the condition. It is reasonable to assume that if the clinical picture fulfills all of the criteria of causalgia, except that of trauma, then non-traumatic syndromes may also more properly be labeled as such.

Compression of a nerve interrupts the functional continuity as much as if it were severed. This is not usually complete. The syndrome which follows complete severance is present but to a much milder degree. If the compression is severe and persistent, complete interruption is the end result.

If the lesion is mild, irritative phenomena are present. The development of the syndrome of causalgia then becomes manifest. If this syndrome of pain becomes intense with minimal peripheral sensory or motor manifestations, the classical causalgia is present. As speculative thought disturbed biochemical change must be present in general systemic disease. Is it not possible that the primary pathologic changes in many obscure diseases will eventually be found in the field of chemistry rather than in the field of histology and bacteriology.

We are apt to consider trauma only as an external agent. If trauma is looked on in a broader sense, injury of any type, one can begin to see the relation of injury from within, namely, an endogenous type, having its origin within the body. This may be the result of toxic products incident to disease or from actual mechanical interference with nerve function.

The relation of psychogenic factors should not be overlooked nor should they cloud the picture so much that the investigation is stagnated. Each disease has its psychic component and a proper perspective is the healthiest approach to a study of the obscure conditions.

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PHYSICAL THERAPY IN SMALL COMMUNITY HOSPITALS

HOWARD A. CARTER, M.E., SECRETARY

and

JOHN S. COULTER, M.D., CHAIRMAN

Council on Physical Medicine of the American Medical Association

CHICAGO

The presidents of three leading medical groups of the nation and the Surgeon General of the United States Public Health Service have emphasized the importance of physical medicine in the postwar medical world and have urged young men and women to take advantage of free training for careers as physical therapy technicians.

Thomas Parran, Surgeon General of the United States Public Health Service, declared that there are already millions of Americans who need physical therapy because of crippling diseases, accidents and war wounds. As the number of older persons in our population increases, Dr. Parran asserted, "other thousands will need physical therapy for the many disabling diseases which afflict old age."

Dr. Herman L. Kretschmer, past-president of the American Medical Association, declared that the need for physical therapy technicians is "most urgent and will increase rather than decrease as time goes on." Dr. Kretschmer also said:

> Possibly no profession associated with the medical world offers more opportunities for a career than does that of physical therapy. Not only will young people taking up this profession provide themselves with a career that has a great future, but they also will be making a distinct contribution to the achievement of the health and welfare of the American people.

Stressing the growing recognition by industry of the value of physical medicine, Dr. Fred Slobe, president of the American Association of Industrial Physicians and Surgeons, said:

> During the manpower shortage created by the war it has been amply demonstrated that the record of the handicapped absorbed by industry has been such that their production, safety, and absentee record have been better than average. This is ample proof of the value of rehabilitation and selective job placement.

According to Dr. Donald C. Smelzer, president of the American Hospital Association, the cost up to now of proper training for a physical therapy technician has been a factor in the inadequate number of qualified men and women in the field.

At the third war conference of the American Hospital Association at Cleveland, it was pointed out that the people in the rural regions are awake to the need of equalization between the health service they now have and that which is enjoyed in urban areas.[1]

It is not believed that physical therapy should reach the rural communities through physical therapy technicians who establish their own offices. The late Dr. D. W. Gudakunst, medical director of the National Foundation for Infantile Paralysis, said:

> Physical therapists, like many other professional groups, have acquired skills, abilities and even, at times, knowledge beyond those of the physician. The doctor orders physical therapy treatment; the physical therapist fills that order. The physician is asking that

1. Editorial: J. A. M. A. 127:91 (Jan. 13) 1945.

things be done for his patient which he himself cannot do. He cannot do them because of lack of time, or lack of specific skill, or for any number of other reasons. This places a grave responsibility on the physical therapist—a responsibility accompanied by a temptation to practice independently of the medical man. All arguments in favor of this are fallacious and short sighted. Avoid the temptation or else the profession is doomed to a role that meets those on the fringes of good medicine. Individuals may prosper for a time, but physical therapy as a profession will die.

The Council on Medical Education and Hospitals of the American Medical Association[2] reported that in registered hospitals there were 2,382 full-time physical therapy technicians in 1936 and 3,220 in 1944. There also has been a gradual increase in a branch of physical medicine, namely occupational therapy. The report mentioned listed 1,809 full-time occupational therapy technicians for 1936 and 2,266 for 1944.

In recent years the public has come to realize that complete therapeutic facilities in a hospital require a department of physical medicine. While most large hospitals are provided with such a department, the hospitals in many small communities are not. The American College of Surgeons has compiled standards for a modest hospital calling for necessary diagnostic and therapeutic facilities.

A physician should be in charge of the department. Our experience indicates that the service is satisfactory when it is entrusted to a specialist, a member of the Society of Physical Medicine, a national organization of physicians specializing in this field. After proper staff relations are established and with adequate personnel in each hospital, a specialist in physical medicine can supervise a district by properly spaced conferences with the staff and personnel followed by telephone service which might adequately meet the needs in the interim. Such cooperation will greatly benefit those who put forth the effort and in a measure will provide better medical service in the community.

The small hospital should have a resident physician.[3] During World War II this was impossible, but now that the war is over there will probably be a number of young physicians available for residencies. They can utilize the opportunity as a transition between service with the armed forces and establishment of a civilian practice. The medical schools and larger hospitals might well send their resident physicians for a part of their training to efficient small hospitals, where the young physician can get the feel of general practice better than anywhere else.[3] This arrangement might make it possible for the small community hospital to have a department of physical medicine.

If a consulting specialist or a resident is not available, it is better to train a local physician and put him in charge of the department than to permit physical medicine to remain at the low level it will occupy if each physician in the community tries to practice physical medicine in his office.

A department of physical medicine to be successful must have a registered physical therapy technician. In our opinion the best technician for hospital service is one who has had nurses' training and nursing experience. The suggestion has been made that a physical therapy technician might also serve as an x-ray and a medical laboratory technician. This combination would require training in three separate technical specialties and therefore a long period of preparation. If there is not sufficient demand for physical therapy in a small community hospital to occupy the full time of a physical therapy technician, the nurse trained in physical therapy can do part time nursing.

2. Hospital Service in the United States, J. A. M. A. 127:781 (March 31) 1945.
3. Southmayd, Henry J., and Smith, Geddes: Small Community Hospitals, New York The Commonwealth Fund, 1944.

The physical therapy technician must be thoroughly trained. At times she may have to administer physical agents according to oral directions given by the consulting specialist. Skill and service of this kind are possible only if she is well qualified and paid a salary equal to that which she can command in the city.

To secure a physical therapy technician who is content to stay in a small community may be difficult because of social and economic conditions. This handicap may often be overcome if the community will interest a capable young nurse connected with the local hospital in taking training in physical therapy. The courses in schools approved by the Council on Medical Education and Hospitals of the American Medical Association are of nine and twelve months' duration. Applicants must have a minimum of two years of college training, including at least twelve semester units of biology and other basic sciences, or be graduates of schools of nursing or physical education.

Often an applicant can obtain a scholarship in an acceptable school. Scholarships are available from the National Foundation for Infantile Paralysis, and they cover transportation and living costs in addition to tuition. Inquiries should be addressed to the National Foundation for Infantile Paralysis, Inc., 120 Broadway, New York 5, N. Y.

Arrangement of Space

A recently published first floor plan for a fifty bed hospital and health center provided for a room 16 by 20 feet for physical therapy.[4] The Council on Physical Medicine has published an article on "Physical Therapy Departments with Fifty or More Beds" which is available for the asking.[5]

A room 16 by 20 feet is the smallest space that should be allotted. It should be on the first floor so that outpatients can receive treatment without going through the hospital corridors. Many outpatients are handicapped and unable to ascend stairs. It is particularly important to have the rooms well ventilated and well lighted. Fresh air is especially vital where exercises are to be given.

The temperature inside is apt to be higher than that outside during the summer months owing to the presence of heat-producing apparatus. Consequently, the patient will be more comfortable if there is cross ventilation.

Two 8 by 10 foot treatment cubicles should be installed. Each cubicle should be equipped with a treatment table 6½ feet long, 30 inches wide and 30 inches high with a shelf 12 inches wide and 12 inches from the floor. Tables can be made by the hospital carpenter. A single bed mattress should be provided for each table. An inner coil spring mattress should not be used.

Two treatment cubicles will allow the physical therapy technician to apply infra-red heat, diathermy or ultraviolet radiation to one patient while giving massage or exercise to another.

Linoleum or a material of rubber composition makes a soft covering for the floor. The technician is on her feet all day; consequently, her efficiency may be decidedly lowered by foot ailments.

The plans for wiring and placing of apparatus should be drawn with a view to the future rather than according to the immediate needs of the department. It is far less expensive to have too many service outlets than to tear up the walls for rewiring later. The plugs connecting the machines to the wall receptacles should be designed to fit only one outlet so that no mishaps, such as blown fuses, will result. The electric outlets should be

4. Hospital Facilities Section, U. S. Public Health Service: A Rural Hospital and Health Center, Hospitals, page 40, July, 1945.
5. Council on Physical Therapy: Physical Therapy Departments in Hospitals with Fifty or More Beds, J. A. M. A. 110:896 (March 19) 1938.

placed 3 to 4 feet from the level of the floor so that they can be reached without stooping. This also facilitates the movement of apparatus.

Equipment

Physical medicine in general hospitals consists largely of the application of common sense and intelligent handwork. Elaborate apparatus and machine therapy do not make a department of physical medicine. The director is advised to keep this truism in mind when outfitting a department.

Minimum requirements for equipment consist of apparatus which may be made by a carpenter and an electrician. Heat can be administered with success without elaborate apparatus. Apparatus should be readily movable; i. e., it should be on casters or should be portable. A small department should have two homemade bakers; one paraffin bath, and apparatus for exercise, such as a shoulder wheel, exercise steps, a shoulder abduction ladder, a kanavel table, an overhead sling and pulley for bed exercises, an adjustable parallel stall bar and a posture mirror. Directions for making simple apparatus may be obtained from the Council on Physical Medicine of the American Medical Association.

If circumstances warrant, the following equipment may be added: one portable diathermy machine, one ultraviolet mercury arc lamp and one galvanic-faradic device.

Charges

The fees charged for physical medicine must be arranged with two principles constantly in mind: (1) to encourage the best care for the patient and (2) to ease his financial burden. The fees in a small community hospital cannot be fixed until more experience has been obtained. The following factors will have to be considered in determining rates: (1) what the treatment costs the hospital, (2) what the patients thinks he is able to pay, (3) what the hospital thinks the patient can pay (4) and what the hospital thinks the community or other agencies will contribute. Southmayd and Smith[3] write that the hospitals in the Commonwealth Fund group had adopted the following method of computing charges: To the basic charge for room, board and nursing care, a fixed amount is added for other services. Consider the surgical patient, for example: This fee covers the full average cost of supplementary services in surgical cases. Obstetric and medical departments follow a similar plan. These fixed surcharges are then added to the basic rate for the number of days the patient is expected to stay, and he can be told in advance exactly what the hospital care for a given period will cost. This in itself is good medicine, and it reduces anxiety.

The inclusive rate plan has clinical and psychologic advantages for the patient. Either he or his physician may hesitate to ask for necessary physical therapy if it will increase the daily cost. Actually it often decreases the total cost by shortening the period of convalescence. Since the physician cannot guarantee a shorter time of recovery, the patient may be reluctant to increase the hospital costs. When the hospital is paid one sum for whatever the patient needs, these doubts are removed. Evanston Hospital in Evanston, Ill., has an inclusive rate plan which includes physical therapy. Dr. Roger DeBusk, the director, believes this works out to advantage.

Another method of payment is the hospital prepayment plan. The Hospital Service Plan Commission of the American Hospital Association recommends that physical therapy be included in all Blue Cross Plans. Twenty-six Blue Cross Plans include physical therapy in their hospital benefits and nine include limited physical therapy. During the past year,

seven plans have added physical therapy to their subscriber contracts.

Physical therapy does not significantly increase the costs in the Blue Cross Plan. Mr. John R. Mannix, executive director of the Plan for Hospital Care, Chicago, in a study of 40,000 patients receiving physical therapy found that intelligently applied physical therapy increased the hospital rate only 2 cents per patient day.

Insurance companies writing workmen's compensation insurance are willing to pay for intelligently applied physical medicine. R. A. Aitken, in charge of rehabilitation center, Liberty Mutual Insurance Company, Boston, recently said:[6]

> The present war has focused much attention on the rehabilitation of our war casualties. Many of our larger military institutions are now so equipped that rehabilitation of the injured begins on admission to the hospital. Physical and occupational therapy are administered to patients confined to bed. Although no official statistics are yet available, there is no question that such prompt treatment will shorten the convalescence of the injured. More important, however, than the time saved are the preservation of morale and the prevention of fixed deformities which follow delayed or inefficient treatment. It is of equal importance that early and efficient treatment be rendered our industrially injured. Unfortunately, the facilities available to the military casualty are not yet available to the industrial casualty. The problem of rendering prompt and efficient cure to those injured on the home front is a challenging one.

The physicians of the United States are interested in extending to all people the best possible medical care. Adequate care in the field of physical medicine should be made available to the American public. Such care can be rendered in small communities only by well trained physical therapy technicians working in hospitals under the direction of licensed physicians. It cannot be given by improperly trained personnel.

6. Aitken, A. P.: Rehabilitation of the Industrial Casualty, Virginia M. Monthly 71:177 (April) 1944.

NOTICE TO CONGRESS MEMBERS

Please take notice that at the last annual business meeting of the Congress, Sept. 6, 1944, in Cleveland, Ohio, the following proposed amendments to the Constitution and By-Laws of the Congress were read and then presented in writing to the meeting:

1. Amend Article I of the Constitution to read:

"The name of this organization is the American Congress of Physical Medicine, hereafter referred to as the Congress."

2. Amend Article II, Section 1, of the Constitution to read:

"The objects of the Congress are to promote and advance the art and science of physical medicine. Physical medicine as here used means the diagnosis of, prescribing for, or treatment of disease, defect or injury by physical means."

3. Amend Article VIII, Section 2, of the Constitution to read:

"The Board of Registry shall meet at least once during the annual session of the Congress and at such other times as may be required."

4. Amend Article X of the Constitution to read as follows:

ARTICLE X—OFFICIAL PUBLICATION

"Section 1. Name. The official publication of the Congress is the ARCHIVES OF PHYSICAL MEDICINE, in which shall be published all official Congress notices and

transactions of sessions of the Congress, either in abstract or in full. The management of the ARCHIVES OF PHYSICAL MEDICINE shall be vested in an Editorial Board to be constituted as provided for in the succeeding section.

"Section 2. Composition of Editorial Board. The Editorial Board shall consist of six members appointed by the Board of Governors, one member to serve one year, one member to serve two years, one member to serve three years, one member to serve four years, one member to serve five years and one member to serve six years. Thereafter as the term of a member of the Editorial Board expires, the Board of Governors shall appoint a successor to serve a six year term.

"If a member of the Editorial Board dies, resigns, or becomes disqualified for further service before the expiration of the term for which he was appointed, the Board of Governors shall appoint a successor to serve for the unexpired portion of the term.

"Section 3. Powers of Editorial Board. The Editorial Board shall direct the policies of the ARCHIVES OF PHYSICAL MEDICINE.

"Section 4. Meetings of Editorial Board. The Editorial Board shall meet at least once during the annual session of this organization and at such other times as may be required."

5. Amend Article XI of the Constitution to read as follows:

"All legislative powers of the Congress, including the power to alter, amend, or repeal this Constitution and the By-Laws, are vested in and reside in the voting members of the Congress, who alone shall have the power and authority to determine the policies of this organization. The voting members shall elect (1) all the officers, and (2) the elected comitteemen."

6. Amend Article XII of the Constitution to read as follows:

"The Congress shall meet at such times and places as may be provided in the By-Laws provided there shall be held annually a meeting which shall be designated as the Annual Meeting at which the Congress shall elect members to succeed officers and committeemen whose terms expire at the beginning of the following meeting, and provided that the Board of Governors may subsequently by majority vote designate a different time and/or place accordingly as necessity, advisability or convenience may indicate. The Congress may be called into special session at any time during the year by the President on the written request of ten members."

7. Amend Sections 1, 2 and 3 of Article XIII of the Constitution to read as follows:

"Section 1. Raising of Funds. Funds for conducting the affairs of the Congress may be raised:

(a) By such annual dues from members of this organization as the By-Laws may provide;

(b) By voluntary contributions, devises, bequests, and other gifts; and

(c) In any other manner approved by the Board of Governors.

"Section 2. Fiscal Year. The fiscal year of the Congress is from January 1 to December 31, inclusive.

"Section 3. Supervision. Supervision of the funds, investments, and expenditures of the Congress is vested in a Finance Committee, which shall consist of three members elected by the members of the organization for terms so staggered that in the year following the adoption of this Constitution and the By-Laws and annually thereafter the organization may elect one member for a three year term. The Committee shall annually designate one of its members to serve as Chairman. The Committee itself, or, if the By-Laws so provide, jointly with such committees as may be provided in the By-Laws, shall annually prepare a budget of the Congress' expenditures for the ensuing year, which shall be presented for approval at a business meeting of the annual session."

8. Amend Article XIV of the Constitution to read as follows:

"The principles of Medical Ethics of the American Medical Association in force at the time of the adoption of this Constitution and as they may from time to time thereafter be amended by the American Medical Association, are the Principles of Medical Ethics of the Congress and are binding on its members."

9. Amend Article XV of the Constitution to read as follows:

"The Congress is a corporation, not for pecuniary profit, incorporated in April, 1930, under the laws of the State of Illinois. If in the future the voting members of the Congress deem the course advisable, the Congress may have its corporate status dissolved and may function as an unincorporated association or under such other form of organization as it deem best. It is the intent of the members of the Congress, having such status at the time of adoption of this Constitution or obtaining such status thereafter, that their respective rights and duties as members of the Congress shall be determined and governed by the provisions of the Constitution and By-Laws. In the event that any provision of this Constitution or the By-Laws is held to be in conflict with, contrary to, or beyond the power conferred by the Articles of Incorporation or other integral part of the so-called charter of the corporation, if necessary to attain the end and effectuate the intent expressed in the preceding sentence, the corporate status of the Congress may be dissolved."

10. Amend Article XVI of the Constitution to read as follows:

"This Constitution may be amended in whole or in part at any annual business meeting by a two-thirds vote of all voting members present and voting provided that prior to that time the amendment

(1) Has been presented in writing at the previous annual business meeting, and

(2) A copy of the proposed amendment, together with a notice that the matter will be voted on, is sent by mail to each member or is published in the ARCHIVES OF PHYSICAL MEDICINE not less than one month in advance of the annual business meeting at which action is to be taken."

11. Repeal Chapter VI of the By-Laws. (This is necessary because it has been suggested that the organizational law with respect to the official publication of the Congress be considered in Article X of the Constitution.)

12. Amend Chapter VII of the By-Laws to read as follows:

CHAPTER VI — SEAL

"The organization shall have a common seal which shall bear the words 'American Congress of Physical Medicine, Seal, State of Illinois'."

13. Amend Chapter VIII of the By-Laws to read as follows:

CHAPTER VII — AMENDMENTS

"These By-Laws may be amended at any regular meeting by the affirmative vote of at least two-thirds of the members present and voting, provided that the proposed amendment has been submitted in writing and has been read at a meeting of the Congress on the day previous to the day on which the amendment is adopted."

A motion was then made, seconded and carried that, in accordance with the provisions of Article XVI of the Constitution and Chapter VIII of the By-Laws the proposed amendments be made of record and that a copy thereof be sent by mail to each member not less than one month prior to the next annual business meeting together with notice that the matter would then be voted on for adoption or rejection.

This is to serve as notice to the members of the aforesaid action at the last annual meeting and as notice that at the forthcoming annual business meeting of the Congress to be held at 8:00 P. M., Sept. 3, 1946, at the Hotel Pennsylvania, New York City, the proposed amendments set out above will be voted on for adoption or rejection.

MEDICAL NEWS

Annual Report of the Special Committee on Physical Medicine Medical Society, County of New York, for 1946

The Special Committee on Physical Medicine of the Medical Society of the County of New York in its annual report states that it has kept up its usual endeavors to forward education in this field.

The committee took special thought to defeat the Anti-vivisection bill, attending the meeting for the formation of the Friends of Medical Research, interesting the laity through literature and personal contacts and letters. Research is a basic part of Physical Medicine and most of their pronouncement were backed up by animal as well as human experimentation. All past statements have been and are being carefully scrutinized and proved or discarded by the latest scientific methods.

A number of vexing problems are still on their way to complete solution. These will be reported by the present or a following committee at a future date. These as stated in the report concern the commercial aspects that dog the footsteps of all medicine, advertising by radio, newspaper, magazine, leaflets, word of mouth, privately and publicly, especially for self-treatment.

Sixteen Medical Consultants Appointed to Assist in Graduate Training Program

Vice Admiral Ross T. McIntire, Medical Corps, U.S.N., Surgeon General of the Navy, has announced the appointment of 16 members of the Reserve Consultants Board to the Bureau of Medicine and Surgery.

The consultants are officers of the Naval Medical Reserve Corps with the exception of the consultant representing the Council on Medical Education and Hospitals of the American Medical Association. All are outstanding specialists in their respective fields. They will assist the Bureau of Medicine and Surgery in furthering the graduate medical training program.

This program, in addition to increasing professional proficiency and improving the standards of medical practice, is designed to afford Naval Medical Officers the opportunity to train in medical specialties and to qualify for American Board certification, fellowship in one of the American Colleges, or other marks of distinction in the same manner as doctors engaged in civilian practice.

The Reserve Consultants Board will aid in establishing the residency training program in nine U. S. Naval Hospitals located in Bethesda, Maryland; Chelsea, Massachusetts; Great Lakes, Illinois; Long Beach, California; Oakland, California; Philadelphia, Pennsylvania; San Diego, California; Seattle, Washington; and St. Albans, New York. Other Naval Hospitals will be utilized for training as the program expands.

The Board will meet and confer at the Bureau of Medicine and Surgery, visit and survey U. S. Naval Hospitals in respect to the graduate medical training program, confer and advise with the Medical Officers in Command and with the Chiefs of Services, and assist in the choice of Reserve Consultants to the staffs of Naval Hospitals.

At the present time the residency-type training program offers courses in the following specialized fields: neuro-psychiatry, dermatology and syphilology, radiology, anesthesiology, internal medicine, urology, obstetrics, orthopedic surgery and pathology. As the program develops it is planned to organize courses in other specialties. Medical officers are also receiving training in civilian institutions in recognized specialties.

The following are members of the Reserve Consultants Board:

Dr. Joseph S. Barr, Instructor, Orthopedic Surgery, Harvard Medical School, Consulting Orthopedic Surgeon, Eye and Ear Infirmary.

Captain F. J. Braceland, Medical Corps, U.S. N.R., Secretary, American Board of Psychiatry and Neurology.

Occupational Therapist Requirements in Veterans Hospitals

The Veterans Administration has long recognized occupational therapy as an important adjunct to definitive medical care and rehabilitation. Under the newly activated Medical Rehabilitation Program of the Veterans Administration, occupational therapy will assume an even more important role as it becomes integrated with all of the other therapeutic activities of the hospital into one coordinated program.

Supplementing the work of the Physical Medicine Service under the augmented Medical Rehabilitation Program will be Shop Retraining and Educational Retraining programs supervised by the Chief of the Medical Rehabilitation Service. The guiding philosophy of the entire program will be to begin active rehabilitation procedures at the earliest possible moment consistent with sound medical judgment following acute illness and continuing in a progressive, graduated fashion until the time of discharge from the hospital. Treatment will be conducted on a personalized basis with occupational therapists, physical therapists, physical reconditioning specialists, shop teachers and academic instructors functioning together as a team to meet the rehabilitation needs of each individual patient. Success of this program

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ARCHIVES of PHYSICAL MEDICINE
OFFICIAL PUBLICATION AMERICAN CONGRESS OF PHYSICAL MEDICINE

.·. EDITORIALS .·.

TO THE MEMBERS OF THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

As the time draws near for the meeting of the Congress in New York September 4, 5, 6, and 7, the details of the meeting are rapidly taking shape.

The Program Committee has been busy the past four months setting up what should be one of the largest meetings in the history of the Congress. Because of the progress made in Physical Medicine in the past few years, both in the armed services and in civilian life, the Committee had a great number of titles for papers submitted for presentation at the meeting.

The program will be well balanced from the standpoint of subject matter, covering the various phases of physical medicine. This will be the first program on which will appear papers from the Baruch Committee and should be of interest. The scientific sessions will be held each morning and three afternoons, Wednesday, Thursday and Friday, September 4, 5, and 6, respectively. Saturday afternoon will be devoted to visiting the various Physical Therapy departments in New York City. These visits should be of interest to everyone attending the meeting. The official opening will be Wednesday evening, September 4th, with outstanding speakers. Thursday evening, September 5th, the annual banquet will be held, at which time distinguished speakers and guests will be presented. There will be no meetings on Friday evening September 6th, to allow everyone to have a free evening for social activities. Watch the July issue of the ARCHIVES OF PHYSICAL MEDICINE for the preliminary program.

The Educational Committee has spent much time and effort in setting up what should be one of the most worthwhile seminars held in conjunction with the Congress. Special emphasis has been placed on basic studies in Physical Medicine. Be sure to see the seminar program listed elsewhere in this issue.

In order to have adequate time for conducting the business meeting it will be set up in two parts; the first part will be held on Tuesday evening, September 3rd, at 8 o'clock; the second part will be held during the time of the convention, which will be announced at that time.

All members should make plans now to attend this session. It is advisable to write immediately for hotel reservations.

OPPORTUNITY

The article in this issue of the ARCHIVES on Physical Medicine in the smaller communities calls attention to a field neglected by the physiatrists. The need has always been present but the demand has never been sufficiently concerted to bring action. In the future more complete and satisfactory facilities will have to be made available than have been supplied by the medical profession in the past in the majority of these communities. Interest in physical medicine was gaining momentum even before the war due to many factors. The war merely accelerated this progress. The many medical officers of the Army and Navy from these localities were given ample evidence of the value of these measures and on their return to practice will certainly use this type of therapy. An

added stimulus will be furnished by the non-medical men of the armed forces. This applies particularly to the many men who were hospitalized and had contact in some way with physical therapy. The general and station hospitals of the Army had departments which had competent technicians and adequate equipment as a rule. Even the smaller units often had technicians on their staff and equipment of some type or other. These people when they return to their communities will expect a greater and more intelligent use of the various physical measures. Right now a substantial group of veterans of this war with injuries or disabilities incurred in line of duty are referred to physicians in the patient's community for care. For these patients it is obvious that the facilities of physical medicine are needed. If the physicians are not able to supply such service, the patients will demand it elsewhere.

The impression that physical medicine is entirely neglected in the smaller communities is incorrect. In practically every small city and town physical modalities are used and used extensively but by irregular practitioners. This situation is not new or is it confined to these smaller communities. The inference might be drawn from the article and the few words of this editorial that conditions as to physical medicine in the cities is ideal. But today how many hospitals in the cities and larger towns do not have physical therapy departments?

The suggestions of Doctor Coulter and Mr. Carter are both specific and practical. At the present time space in all hospitals is at a great premium, and physical therapy technicians are most difficult to secure. However, better days can be hoped for and plans can be made now for the future. And in any plans for the future the program of rehabilitation will have to be considered. This reconditioning of patients which was begun for the armed forces will certainly be utilized in some form for civilian practice. Numerous articles have already appeared outlining this new conception of therapy for civilian hospitals. The entire program as followed in the Army will not be applicable to the civilian hospital, however, certain phases of the plan will sooner or later be incorporated in the management of many patients. The words of Dr. Richard Kovács on rehabilitation are worth quoting, "There are vast and hitherto practically untouched possibilities for mental and physical reconditioning of patients in hospitals of every description by physical, occupational and psychotherapy." Such a program will cause radical changes in the physical plant of all hospitals in both large and small communities.

The readers of the ARCHIVES need this advice and information the least. It is the physicians in these communities who should read the article. One easy means of reaching them would be to have reprints sent to each county medical society. The possibility of creating attention is worth the effort.

Medical News
(Continued from page 350)

will be partially dependent upon the ability of the Veterans Administration to secure an adequate number of skilled, professionally trained occupational therapists.

Of the 692 positions as therapists allocated at the present time, there are 247 vacancies of all grades. At the present time 47 occupational therapy apprentices are in training in Army hospitals. These apprentices will be transferred to selected VA neuropsychiatric hospitals for two months' clinical training with mental patients. Following this training they will be assigned to various Administration Hospitals. This will reduce the current list of vacancies to 200. These 200 vacancies are equally divided between therapists and assistants. Occupational Therapists are badly needed to work in Tuberculosis Hospitals.

Expansion of the program and the opening of new hospitals will cause additional need for therapists of all grades. It is estimated the 692 currently authorized will be increased to 739 by June 30, 1946; 835 by September 30, 1946; 961 by March 31, 1947, and 1,318 by June 30, 1947. There is at present an acute shortage particularly of male therapists for neuropsychiatric hospitals.

The pay scales for occupational therapists in the Administration are: Staff therapists, SP-6, $2,320 minimum to $2,980 maximum; Assistant Chief Therapists or Chief Therapists, SP-7, $2,650 minimum to $3,310 maximum; Assistant Chief Therapists or Chief Therapists, SP-8, $2,980 minimum to $3,640 maximum: Assistant Chief Therapists or Chief Therapists, P-3, $3,640 minimum to $4,300 maximum; Chief Therapists, P-4, $4,300 minimum to $5,180 maximum.

Information concerning opportunities in the Administration can be obtained from Branch Office or Administration stations, hospitals, or centers. Applications should be made on Civil Service Form 57 and sent to the Branch Office or Hospital of the Veterans Administration in the area in which the applicant wishes assignment.

There is an urgent need at present for qualified therapists at the following stations: Castle Point, New York; Excelsior Springs, Missouri; Ft. Bayard, New Mexico; Legion, Texas; Livermore, California; Oteen, North Carolina; Outwood, Kentucky; Rutland Heights, Massachusetts; San Fernando, California; Sunmount, New York; Tucson, Arizona; Walla Walla, Washington; Waukesha, Wisconsin and Whipple, Arizona.

Radar Pulses Apparently Harmless, Surgeon General's Experiments Show

Ten centimeter electromagnetic waves, such as constitute radar pulses, apparently are harmless. This has been determined by intensive exposures of guinea pigs to this radiation at the Aero Medical Laboratory at Wright Feld. The experiments are described in a report to the Office of the Surgeon General by Lieut. Col. Richard H. Follis, now of Duke University.

These extremely short radio waves first came into extensive use during the war in military equipment and army and navy personnel necessarily were exposed to them for long periods. Their biologic effects were entirely unknown, although there was no reason to suppose that they would be in any way detrimental. Nevertheless disquieting rumors arose and attained considerable circulation that long exposure to the radiation might cause baldness or even sterility.

Presumably the rumors were due to confusion with known effects of x-rays and ultraviolet radiation, both of which are at the other end of the spectrum. There, wavelengths are much less than those of visible light whereas the ten centimeter waves are thousands of times longer, and are called "short" only in comparison with other radio waves.

At the Wright Field laboratory Dr. Follis exposed 13 male guinea pigs to ten centimeter radiation three hours daily for from 51 to 53 days. At the end of this time they were killed and every vital organ studied. Absolutely no deviations from the normal were found. There was no loss of hair, and no evidence of sterility. It also was determined that no x-radiation, which might have been harmful, was mixed with the radio waves.

Early in the war clinical studies were made of navy volunteers exposed for long periods to high frequency radio waves, although not in measured amounts such as were used in the guinea pig experiments. No pathologic effects were found. Some of the subjects had complained of headaches after several hours of exposure, but these disappeared shortly after exposure was ended.

Ray Clinics Dedicated

The Veterans Administration passed a milestone when it dedicated its new medical rehabilitation clinic in the VA regional offices at 252 Seventh Avenue, New York City.

Known as the Ray Clinics in honor of James Ray, an infantry officer for whom the Medal of Honor was posthumously awarded for deliberately sacrificing his life for his country, the clinic marks a great step toward realization of the policy of General Omar Bradley, VA Administrator, that disabled veterans of this war should have the best possible medical rehabilitative care that a grateful country could offer.

One of the busiest units of the clinic is the orthopedic and prosthetic appliance shop. In this complete unit almost 100 physicians, limbmakers, orthopedic mechanics and other technicians give a complete service, ranging from diagnosis and treatment by the physicians, to the construction of arms, legs, braces, trusses, belts, orthopedic shoes and arch supports.

Of the estimated 2,300 World War II amputees in the New York metropolitan area, more than 1,500 have visited the clinic. Artificial limbs, like

any other mechanical device, frequently need minor repairs and adjustments. — Rusk, N. Y. *Times.*

Medical Specialists to Western Reserve University

In a move to make the School of Medicine, Western Reserve University and University Hospitals an important center for the study and promotion of disease prevention, five outstanding U. S. Army medical scientists will join the university and hospital staffs this summer.

One of the scientists, Dr. John H. Dingle, will occupy the Elizabeth Severance Prentiss chair as professor of preventive medicine to succeed Dr. James A. Doull, who has joined the staff of the United States Public Health Service. Dr. Dingle is director of the commission on acute respiratory diseases in the U. S. Army Epidemiological board.

This was announced by President Winfred G. Leutner of Western Reserve and Dr. Robert H. Bishop, Jr., director of University Hospitals, who said the other appointees to the medical school and hospital staffs are Drs. George F. Badger, A. E. Feller, C. H. Rammelkamp, and R. G. Hodges. They all worked with Dr. Dingle as members of the commission.

Dr. Badger has been named associate professor of biostatistics, while the others will hold appointments in the departments of medicine and pediatrics in the School of Medicine and will also be members of the staff of University Hospitals.

Committee on the Teaching of Physics for Students of Biology and Medicine

Following a recommendation from the Scientific Advisory Committee of the Baruch Committee on Physical Medicine to the Executive Committee of the American Association of Physics Teachers, a committee of three members of the association has been formed to assist in a more effective teaching of physics for pre-medical students and students of biology.

The efforts of the committee are to be directed along two lines: (1) to assemble and make available to teachers of the first course in college physics, illustrative material from biology and medicine which will show physical principles at work in biological processes and physical principles applied in the study of biological processes; (2) the planning of a second course in physics for students of biology and pre-medical students.

The committee is confident that there are many biologists, physicists and physicians interested in this project who will have valuable suggestions. We invite your council at an early date.

Please send correspondence to:

LeRoy L. Barnes, Rockefeller Hall, Ithaca, N. Y.

The Committee,

Lester I. Bockstahler.
Louis A. Strait.
Le Roy L. Barnes,
Chairman.

Hospitals Approved for Residency Training in Physical Medicine

[1]Los Angeles County Hospital, Los Angeles.
[1]Massachusetts General Hospital, Boston.
Mayo Foundation, Rochester, Minnesota.
Michael Reese Hospital, Chicago.
[1]Montefiore Hospital for Chronic Diseases, New York City.
[1]Mount Sinai Hospital, New York City.
Passavant Memorial Hospital, Chicago.
[1]Presbyterian Hospital, New York City.
St. Luke's Hospital, New York City.
Stanford University Hospitals, San Francisco.
[1]State of Wisconsin General Hospital, Madison, Wisconsin.
[1]University of California Hospital, San Francisco.
[1]University Hospitals, Minneapolis, Minnesota.
Walter Reed General Hospital, Washington, D. C.
University of Kansas Hospital, Kansas City, Kansas.

1. Indicates temporary approval.

Profession Status in Civil Service

Professional status for physical therapists with college degrees has been granted by the Civil Service Commission.

The physical therapists who are not qualified by a college degree or the equivalent will be granted the following sub-professional status depending on experience and the duties performed:

SP-5 Graduate of an approved school but without experience.
SP-6 1 year experience.
SP-7 2 years experience.
SP-8 3 years experience.
P-3 4 years experience.

Applications are made directly to the Deputy Administrator of each area, regional office, or to the Manager of each hospital.

Make Hotel Reservations Early for New York Session

BOOK REVIEWS

REHABILITATION — ITS PRINCIPLES AND PRACTICE. By *John Eisele Davis,* M.A., Sc.D. Veterans Administration Facility, Perry Point, Maryland. Revised and enlarged edition. Cloth. Price, $3.00. Pp. 264. New York: A. S. Barnes & Company, Inc., 1946.

This book deals primarily with the problem of rehabilitation of the mentally ill. This revision is noteworthy by reason of the inclusion of much information accumulated by war experiences. Considerable space is devoted to combat fatigue with discussion of the etiological factors and therapy, particularly occupational and recreational therapy. In the chapter entitled "Psychiatric Approach" there are numerous quotations describing classification and newer methods of treatment. Under the chapter heading "Psychological Approach" a large variety of tests are briefly described, ranging from intelligence evaluation to manual dexterity and personality traits without much critical comment. In another chapter the importance of interest and effort is stressed. Other chapters emphasize the same or similar objectives with liberal quotations from a variety of authors. Occupational therapy technics for mental patients are finally discussed in considerable detail.

Although there is present in this volume valuable data concerning the treatment of the psychiatric patient, it does not seem to be well organized or critically presented. The level of presentation does not meet squarely the needs of the physician or the occupational therapist, being somewhere between the two. As a reference source it should be of some value to both groups, particularly students.

THE INTERVERTEBRAL DISC WITH REFERENCE TO RUPTURE OF THE ANNULUS FIBROSUS WITH HERNIATION OF THE NUCLEUS PULPOSUS. By *F. Keith Bradford,* M.D., and *R. Glenn Spurling.* Cloth. Price, $4.00. Pp. 192, with illustrations. Springfield, Illinois: Charles C. Thomas, Publisher, 1945.

In this small monograph the authors have covered the recent material on and discussed the entire problem of rupture of the annulus fibrosus wtih herniation of the nucleus pulposus. The book is divided into ten chapters which include a discussion of the embryology, anatomy, physiology and pathology of the intervertebral disc, clinical and roentgenologic investigation of patients with low back and sciatic pain; clinical observations in lumbar herniations of the nucleus pulposus, treatment and results. The last three chapters are concerned with the history and observations in herniated nucleus pulposus and allied conditions and cervical and thoracic herniations of the nucleus pulposus. The authors also give thirteen case reports.

This is the second edition of this monograph. The first portion, namely, the discussion of anatomy, physiology and pathology, is essentially the same as it was in the first edition. However, the authors have added considerable material concerning the examination of the patient, lumbar puncture, information concerning motor and sensory testing and findings, and have discussed minor changes in the operative procedures. About twenty-five new illustrations, thirty-four pages and forty-nine new references have been added to the first edition. It is well organized and documented and it should be valuable to those interested in the diagnosis and treatment of this rather common condition.

SHOCK TREATMENTS AND OTHER SOMATIC PROCEDURES IN PSYCHIATRY. By *Lothar B. Kalinowsky,* M.D., Research Associate in Psychiatry, College of Physicians and Surgeons, Columbia University, and New York State Psychiatric Institute and Hospital; Assistant Neurologist, Neurological Institute of New York, and *Paul H. Hoch,* M.D., Assistant Clinical Psychiatrist, New York State Psychiatric Institute and Hospital; Instructor in Psychiatry, College of Physicians and Surgeons, Columbia University. Foreword by *Nolan D. C. Lewis,* M.D., Professor of Psychiatry, College of Physicians and Surgeons, Columbia University; Director of the New York State Psychiatric Institute and Hospital. Fabrikoid. Price, $4.50. Pp. 294. New York: Grune & Stratton, 1946.

The so-called shock treatments in psychiatry have now been used all over the world for more than ten years. The introduction of these and some other somatic treatments has made a great impression on psychiatric theory and practice, and as a consequence a large proportion of the psychiatric literature has been devoted to the problems arising from these methods of therapy. There are many splendid articles dealing with various aspects of these problems, but few attempts have been made to give a systematic presentation of the development of the new technics. The authors offer a concise account of the subject of shock and of the new therapeutic procedures, discussing the clinical as well as the theoretic issues involved and relating the experience and ideas of the various psychiatric schools with their different concepts, in an effort to arrive at a fair and unbiased appraisal of the widened therapeutic field. Chapter I describes the historical development of shock treatment; Chapter II, insulin shock treatment; III, the convulsive therapies, pharmacologic, electric; IV, combined insulin-convulsive treatment; V, other somatic nonsurgical treatments and their relation to the shock treatments. The authors conclude that the shock treatments today are indispensable tools of psychiatric ther-

apy; they will stay with us until better methods are evolved. All the available evidence indicates that they are effective weapons in the treatment of certain types of mental diseases. So far, however, their curative value is limited, especially in patients suffering from chronic disorders, and their therapeutic efficacy, e. g., in schizophrenia, must be greatly increased before they can be considered true remedies. This comprehensive volume based on rich experience in clinic and research will be welcomed by psychiatrists and psychologists for practical application and by general practitioners and medical and surgical specialists for orientation.

ELEMENTARY ELECTRIC CIRCUIT THEORY. By *Richard H. Frazier,* Associate Professor of Electrical Engineering, Massachusetts Institute of Technology. Cloth. Price, $4.00. Pp. 434, with 42 illustrations. New York and London: McGraw Hill Book Company, 1945.

The electrical and electronic equipment used in Physical Medicine is becoming more and more complicated. There is a definite need for a book like this on fundamental electric circuit theory. It is written as an elementary textbook for engineering students. It is not free from mathematics, but the mathematics is presented in such a manner that it can be followed without too much mathematical training. Such subjects as the use of complex algebra without which no up to date work in electric circuit theory is possible are discussed at length. For those in physical medicine who want a real knowledge of electric circuit theory without expecting to become graduate engineers this book is ideal. Questions and problems are included so that the student can test his own knowledge. All in all this is a book that can be highly recommended and the hours spent in studying it will pay rich dividends to those interested in electrophysiology and electrotherapy.

POET PHYSICIANS. By *Mary Lou McDonough.* Cloth. Price, $5.00. Pp. 210. Springfield, Illinois: Charles C. Thomas, Publisher, 1945.

This book is a compilation of poems written by physicians from 699 A. D. to the present time. The editor states that it has been possible to select only a small portion of the poetry that has been written by medical men. It was intentional to restrict the scope of the book solely to poetry written by physicians. She stated further that she realizes she undoubtedly will be criticized for her choice of many and for omission of many valuable poems which may have been missed in the Library of Congress, Army Library and numerous private libraries which have been open to her.

A brief bibliography and introduction include a description of the times and activities of the physician who wrote the poem or group of poems. The selection of the works of the various poet physicians is excellent. The short bibliography and discussion of the times in which the poet lived are well written.

The book should be of considerable interest to anyone who is interested in classical and nonmedical writings of physicians. Although the poems do not concern medical subjects, the relation of these men to the practice of medicine may have influenced their writing. Many of the poets whose work is presented may have long been forgotten as physicians but their works as poets have lived for many centuries. The book is well worth having in a personal library of physicians or anyone else interested in literature.

DOCTOR! DO TELL! By *Victor F. Marshall,* M.D. Fabrikoid. Price, $2.50. Pp. 235 with 6 page plates. Appleton, Wisconsin: C. C. Nelson Publishing Company, 1945.

As stated on the jacket this book consists of anecdotes and the human interest side of a surgeon's forty odd years of practice. You will enjoy reading this book immensely and for many reasons. We hear so much about what has become of the general practitioner. After reading Dr. Marshall's story we feel that he has done much to perpetuate the ideal of the successful and we think indispensable physician in a small community. The publishers, too, are to be congratulated on the format which makes for easy and entertaining reading. You will be impressed with the honesty and sincerity that speaks through the pages. The development of medicine of the last forty-five years is portrayed including sulfonamides and the Rh factors.

PATTEE'S DIETICS. By *Alida Frances Pattee.* Revised by *Hazel E. Munsell,* Ph.D., and Others. Twenty-third Edition. Cloth. Price, $3.50. Pp. 736 with illustrations. New York: G. P. Putnam's Sons, 1946.

The twenty-third edition of this well known work is the first revision to be published since 1940. It is largely the work of Hazel E. Munsell, Ph.D., technical adviser to the late Alida Frances Pattee in previous editions. Dr. Munsell was for eighteen years with the Bureau of Home Economics, United States Department of Agriculture and is nationally known for her research on vitamins. Dr. Munsell has had the assistance of other authorities particularly in the sections dealing with diet therapy and practical application of the principles of nutrition and has continued Miss Pattee's plan of calling on physicians to discuss the matter of diet in fields in which they are specialists. For those interested in feeding the sick or who wish to know something of the basic principles of dietetics without the extensive study required to master this particular field the book is recommended.

PHYSICAL MEDICINE ABSTRACTS

Pulmonary Function Tests. A Discussion of Ventilatory Tests. A Description of a Method for Measuring the Diffusion of Oxygen and Carbon Dioxide in the Lungs. George G. Ornstein, Myron Herman, Marcella W. Friedman, and Ernest Friedlander.

Am. Rev. Tub. 53:331 (April) 1946.

The ventilatory and diffusion phases of pulmonary function are discussed. Methods of ventilatory measurements are discussed. The authors stress that the most valuable ventilatory measurement is a ventilatory reserve based on the number of times the maximum minute breathing capacity is greater than the resting minute ventilation. The normal in males is twenty times the resting minute ventilation. The normal in females is thirteen times the resting minute ventilation. A method for measuring the diffusion of oxygen and carbon dioxide in the lungs is described. The ability of lung tissues to diffuse oxygen and carbon dioxide, as measured by a rebreathing bag test after a standard exercise, was recorded in 23 normal males and 25 normal females. Case reports of impaired lungs with their diffusion tests to oxygen and carbon dioxide are presented. The impressions of the authors have been based on such tests on 170 patients with impaired lungs. A concept of ventilation of lung tissue, based on the tensile strength of normal and diseased lung tissues, is discussed.

Sensitization of Cells to Heat by Visible Light in Presence of Photodynamic Dyes. Arthur C. Giese, and Elizabeth B. Crossman.

J. Gen. Physiol. 29:201 (March 20) 1946.

While it has been shown previously that ultraviolet light sensitizes cells to heat no one seems to have tried the effects of visible light in the presence of photodynamic dyes for this purpose. Since the amount of energy available in quanta of visible light is so much less than that available in the ultraviolet it is possible that no sensitization occurs. On the other hand it is well known that in the presence of photodynamic dyes enough energy of visible wavelengths is absorbed to kill. If the dye absorbing the energy can reach the sensitive molescules or can transfer the energy to them, sensitization should occur. Positive results are reported; in other words, a sublethal dosage of visible light in the presence of photodynamic dyes, followed by a sublethal dosage of heat results in death, even though the additive effect of the two in reverse order does not kill. The implications of these results are considered in the discussion.

Visible light of high intensity does not injure paramecia or sensitize them into heat. If photodynamic dyes are added, paramecia are readily killed by visible light of high intensity and are sensitized to heat by sublethal dosages of light. Cells so sensitized are killed when subjected to a sublethal exposure to heat.

If the light and heat are applied in the reverse order, namely, heat and then light, no ill effects are observed. When the concentration of dye is reduced a larger light dosage is required. Recovery from sensitization is slow, requiring about four days for a three-fourths lethal dosage. Sublethal dosages of light in the presence of dyes do not affect the division rate even when three-fourths the lethal dosage has been used. A possible explanation for the photodynamic sensitization to heat is discussed.

The Value of Speransky's Method of Spinal Pumping in the Treatment of Rheumatic Fever and Rheumatoid Arthritis. Theodore Gillman, and Joseph Gillman.

Am. J. M. Sci. 211:459 (April) 1946.

The etiology of rheumatic fever is still unknown. Streptococci, septic foci, bowel intoxication, malnutrition, climatologic factors and allergy, each in turn, have been held responsible for exciting this disease. Apart from the relief afforded by salicylates, the treatment of the heart and joint lesions is still unsatisfactory, and it is not possible at present to prevent the chronic invalidism resulting from the involvement of the heart or of the joints.

Speransky, one of Pavlov's students, has emphasized the role of the nervous system in the causation of disease and in determining many manifestations not otherwise satisfactorily explained. By accepting as a working hypothesis that disease is not merely an expression of deranged normal function but indeed is an entirely new phenomenon having no counterpart in health, he was led to adopt unorthodox procedures in studying pathological processes and in fashioning entirely new therapeutic methods. One method introduced by Speransky into clinical medicine is "spinal pumping." This he has applied in the treatment of 100 patients with polyarthritic rheumatism.

It is suggested that, with due regard for the difficulties of evaluation, it appears that spinal pumping may arrest the progress of rheumatic fever, especially in the acute and subacute stages, and may be of value in the early stages of rheumatic pancarditis.

Since this study tends to confirm Speransky's observations on the value of spinal pumping in the treatment of the various manifestations of rheumatic fever, and in view of the significant changes induced in the peripheral vascular system by this form of therapy, it is recommended

that this method be given further trials on a larger series of cases under controlled conditions.

Cardiac Enlargement in Fever Therapy Induced by Intravenous Injection of Typhoid Vaccine. H. Stephen Weems, and Albert Heyman.

Arch. Int. Med. 77:316 (March) 1946.

Enlargement of the heart has been noted by roentgenograpic examination to occur during fever therapy in 8 to 15 patients with neurosyphilis. Roentgenograms of the heart were obtained on 24 additional patients who had undergone fever therapy during the preceding twelve months. In 4 of these patients, cardiac enlargement was present for as long as six months following hyperpyrexia.

Electrocardiographic studies and determinations of cardiac output, blood proteins and hemoglobin revealed no significant differences between the patients in whom cardiac enlargement developed and those without changes in size of the heart.

In the patients there appeared to be no relationship between the increase in cardiac size and the changes in blood volume. Evidence is produced to show that in normal subjects a rapid and significant increase in the circulating blood volume had no influence on cardiac size.

None of the factors known to influence cardiac size, such as anemia, nutritional deficiency or overwork of the heart, was thought to be the sole cause of the cardiac enlargement.

The observation that fever therapy produces an enlargement of the heart is of interest not only in the treatment of neurosyphilis but also in the consideration of the effects of febrile illnesses on cardiac function. The use of fever therapy provides an opportunity to study these effects under controlled conditions, and suggestions as to further investigation of this problem are offered.

An Analysis of the Klippel-Feil Syndrome. C. A. Erskine.

Arch. Path. 41:281 (March) 1946.

In 1912 Klippel and Feil described the pathologic anatomy of absence of the neck in a 46 year old man. The anatomic basis of the syndrome since known by their names consists essentially in a congenital fusion and numerical reduction of the cervical vertebrae. Since the original description of this rare condition, most of the communications have been reports of clinical cases of a less extreme type. The three characteristic clinical features of the syndrome are shortness of the neck, limitation of movement of the head and lowering of the hair line.

From the example of the Klippel-Feil syndrome presented and from the case reported in the literature it is concluded that the essential features of the cervical deformity are synostosis of two or more cervical vertebrae and flattening and widening of the vertebral bodies. A numerical reduction of the vertebrae is an incidental rather than an essential part of the disorder, as in spina bifida. The latter depends largely on the degree of abnormality of the vertebral bodies. There is evidence that the anomaly has a genetic basis. A number of pathologic conditions which have been found in association with the osseous deformity of the syndrome receive an explanation in the light of recent observations in the field of experimental embroyology.

Allergy of Joints. Leo H. Criep.

J. Bone & Joint Surg. 28:279 (April) 1946.

Allergic arthropathies may be classified as follows: The first group includes instances of long-standing, chronic infectious arthritis which are thought to be due to bacterial allergy. Little is known about the allergic nature of this group and it is not included in this presentation.

In the second category is articular swelling resulting from sensitivity to a foreign serum or to a drug. This condition is usually transitory and is easily recognized as allergic, because it is a part of a generalized reaction to serum or drug.

The third group includes intermittent hydrarthrosis, which is a massive recurrent swelling of a joint, usually the knee. It is found more frequently in women than in men, and is accompanied by effusion of fluid into the joint.

In the fourth group are cases of Henoch's purpura associated with articular swelling and pain which, in some instances at least, might be due to allergy.

The fifth group comprises cases of acute transient paroxysmal articular involvement of joints, characterized by pain, swelling, and limitation of motion. Clinically, the cases simulate subacute arthritis, except for the absence of elevation of temperature, leukocytosis, increased sedimentation rate, and positive roentgenographic findings. This condition is transitory and recurrent and is associated with other allergic conditions, such as migraine, urticaria, angioneurotic edema, asthma and hay fever. Eosinophilia may be present. Positive skin tests may be elicited. The allergic nature of the condition is proved by clinical trial.

It is with this last type of joint involvement that the paper is concerned. The patient complains of excruciating pain which is migratory, sometimes involving the joints of the fingers, at other times involving the vertebral articulations or other joints of the body. At the time of the examination, nothing may be found and the patient may be labeled psychoneurotic. On the other hand, the diagnosis of subacute or even of acute rheumatic fever may be made, and the patient may be confined to bed needlessly for a long period of time.

The mechanism of production of symptoms is probably the same as that in urticaria or angioneurotic edema; the shock tissue is the synovial membrane of the joint, instead of the skin. Considerable, but transient, peri-articular edema may occur and at times there may even be a small amount of transudate into the joint cavity. This fluid may or may not be rich in eosinophils. The reaction, however, is reversible. The allergy is due to sensitivity to foods and absolute elimination of these foods may result in complete relief.

Early Postoperative Rising. A Statistical Study of Hospital Complications. James B. Blodgett, and Edward J. Beattie.

Surg., Gynec. & Obst. **82**:489 (April) 1946.

There has recently been a revival of interest in early postoperative rising and walking. In June, 1942 a critical study of early postoperative ambulation was undertaken at the Peter Bent Brigham Hospital. The preliminary results of these studies are the basis for this communication.

A controlled, preliminary study of early postoperative rising and walking is made on patients having major intra-abdominal surgery. A total of 681 cases were analyzed for postoperative complications and their causative factors. Early rising is defined as rising and walking on the first or second postoperative day.

The patients who rose early were considerably stronger and had less pain in their wounds. They were able to care for themselves on about the fourth postoperative day and were ready for discharge considerably earlier than the control group. The incidence of wound disruption and wound infection was reduced in the early rising group. The incidence of pulmonary complications was somewhat lower in the early rising group. The incidence of deep leg vein thrombophlebitis was observed to be somewhat greater in the early rising group.

Osteomyelitis in Infants. Robert A. J. Einstein, and Colin G. Thomas, Jr.

Am. J. Roentgenol. **55**:314 (March) 1946.

Osteomyelitis in infants shows anatomical and clinical differences from the diseases in older children and adolescents. Prognosis as well as treatment is affected by these differences. These have been recognized by several observers in recent years who have placed the disease in a special category.

Ten cases of osteomyelitis in infants under six months of age are reported. The benign course of the disease and its differences from the disease in older children are emphasized. The pathologic process was reversible in several cases and the clinical recovery in all cases was complete. Roentgenograms are invaluable in detecting the presence of the disease, in following its different phases and in evaluating the end-results. Involvement of a joint is common and is the most serious complication. Good treatment consists of: (a) supportive measures; (b) early, adequate drainage of the soft tissue abscesses; (c) immobilization; (d) chemotherapy.

Toxic Manifestations of Large Doses of Vitamin D as Used in the Treatment of Arthritis. William D. Paul.

J. Iowa M. Soc. **36**:146 (April) 1946.

Large doses of vitamin D may cause severe hypervitaminosis. Hypervitaminosis D occurs more readily with a high calcium intake, especially milk. The total dose of vitamin D which may cause toxicity varies greatly. The dose of vitamin D should be based on body weight, rather than age, and whether or not it is given in milk. The usual toxic symptoms of vitamin D administration are headache, nausea, vomiting, diarrhea, epigastric fullness, polyuria, and polydipsia. The signs of toxicity are low specific gravity of the urine, traces of albumin in the urine, inability to concentrate urine, increased serum calcium, renal failure, retention of nonprotein nitrogen, deposition of calcium in soft tissues, deposition of calcium in arteries and arterioles and, eventually, death. Massive doses of vitamin D do not alter the ultimate course of arthritis and the value of this drug in this disease is questioned. Whenever massive doses of vitamin D are prescribed, the urine should be examined frequently and serum calcium levels should be obtained.

Traumatic Ossifying Myositis. Campbell Howard.

U. S. Nav. M. Bull. **46**:279 (May) 1946.

Five cases of ossifying myositis are reported, four of which were the result of football injuries, representing over 1 per cent of the cadets actually participating in the sport. Translating this proportion to the number of people engaged in football through the country we would have far more cases reported than heretofore. The potential dangers of this condition are pointed out. The use of x-ray therapy is suggested.

Segregated Training for Recruits With Minor Orthopedic Disabilities and Complaints. Leon O. Parker, and Karl V. Kaess.

U. S. Nav. M. Bull. **46**:279 (May) 1946.

Every medical officer in the Navy is familiar with the high percentage of complaints concerning the skeletal system and the frequent skeletal disabilities among Naval personnel. As a result of the great expansion of the Navy and lowering of the physical requirements, these complaints and disabilities were greatly increased, especially among men who were inducted.

Of the recruits entering training stations, many exhibit these minor disabilities and complaints and others develop them in training. To prevent this group from graduating from "boot camp," it became necessary either to survey an unduly large percentage or to apply remedial methods.

During the time that this program was in effect, 30,475 men were received and 33 companies of 100 men each were segregated. This program came into effect at a time when the war had been in progress for 2½ years. Hence many of these recruits had been reclassified for induction from the 4F group. The greater percentage were segregrated for orthopedic reasons, although a few were put in the same companies for dental reasons or as psychiatric trial duties. This was not by choice but for convenience. The medical department found it easier to give these men remedial treatment and to give them special follow-up orthopedic re-examination under this system of segregation.

It proved very effective in the early elimination by survey of recruits with true disability before they became service-aggravated.

It cut to a minimum the number of recruits graduated who had so many subjective complaints that they were worthless as Naval personnel.

No recruit was graduated who had not gone through a satisfactory program of training with the same standard of physical fitness at the end of training that was required of the ordinary recruit. They had not been coddled. Men with defects that could not be corrected up to standard were not graduated. However, some men who had shown progress, but who had not become totally asymptomatic, were given more remedial exercises.

It was found that most of these companies developed to such an extent that they competed favorably with the regular companies, and some of them even won pennants in competition with the regular companies.

The only way accurately to evaluate the results of this program would be to follow this group of men through their Naval career and compare them with a similar group of physically defective recruits who had gone through the usual training.

Injuries of the Elbow in Children. George W. Chamberlin.

Pennsylvania M. J. 49:735 (April) 1946.

Traumatic lesions about the elbow which occur in patients before the age of fusion of the secondary centers of ossification are of interest largely because they differ from those seen in adults.

It is generally agreed that the most common site for fractures in childhood is in the forearm. The second most common location seems to be about the elbow joint. Fahey states that 13 per cent of all fractures of childhood involve the distal end of the humerus.

An analysis of 86 consecutive elbow injuries in children shows that fractures at the supracondylar level of the humerus are, by far, the most common type of injury in this region. Fahey's statistics from his series of 100 consecutive patients confirm our findings of the high incidence of supracondylar fractures in children.

The anatomy of the child's elbow differs from that of the adult. This factor produces an entirely different fracture deformity in the two age groups, although the forces applied may be similar. The second most common injury, in our experience, is separation of the median epicondylic epiphysis. The possibility of a displacement of the pecondylic epiphysis into the joint space must be considered in all children with a dislocation or reduced dislocation of the elbow joint.

Open reduction has been necessary in all patients who have exhibited complete intracapsular displacement of the median epicondyle. Epiphyseal separation of the capitellum is not uncommon. It is frequently associated with a fracture of the lateral condyle of the humerus. Dislocations of the head of the radius, fractures of the head or neck of the radius, T fractures and Y fractures of the humerus, and fractures of the olecranon or coronoid processes of the ulna are uncommon in children.

Traumatic Rupture of Adductor Muscles of the Thigh. George Crile, Jr.

U. S. Nav. M. Bull. 46:723 (May) 1946.

In the past year three so-called "hernias" of the adductor muscles of the thigh have been seen at the U. S. Naval Hospital, San Diego. Observations on these cases have indicated that these deformities are not true hernias and cannot be corrected by repair of the fascia.

A muscle hernia retracts when the muscle is tensed and bulges when the muscle is relaxed. This test affords a certain method off differentiating the muscle hernias of the lower leg from varicose veins. When the examiner holds the toe of the foot down and tells the patient to raise his toe, the anterior tibial muscles are tensed and the hernia disappears. The same thing is true of muscle hernias elsewhere. But in the so-called adductor muscle hernia the opposite is true. The bulge is not obvious when the muscle is relaxed and appears only when the adductor muscles of the thigh are tensed.

The so-called "adductor muscle hernia" is in reality a traumatic rupture of the adductor muscles of the thigh. Correction of this deformity cannot be accomplished by repair of a supposed defect in the fascia. In early cases it is possible that good results could be obtained by repair of the ruptured muscles, but in late cases atrophy, contraction, and fibrosis make it impossible to effect a satisfactory repair. Conservative treatment and reassurance is recommended for patients with ruptured adductor muscles. If the presence of the mass is of cosmetic importance, it can be excised, but the symptoms may not be relieved.

Minor Dislocations. W. E. Tucker.

Practitioner 156:253 (April) 1946.

This article deals mainly with some of the common subluxations and dislocations of the joints and extremities. A dislocation or subluxation may be associated with a fracture of the articular surfaces or of the shaft of the bones, when it constitutes a major disaster; fracture dislocations of the spine or hip joint fall into this category and therefore do not come within the scope of this article.

A detailed history of the injury should be taken. Skiagrams should be taken before and after reduction. In certain joints before active use with strain is allowed, further films are taken to exclude excessive formation of bone. Complications, such as nerve or circulatory damage, must be excluded. Treatment includes careful reduction; support to the joint for varying periods of time according to severity of damage and whether the joint is weight-bearing; dispersing traumatic effusion; restoration of full range of involuntary and voluntary movements as well as muscle power and balance.

AMERICAN REGISTRY OF PHYSICAL THERAPY TECHNICIANS

30 North Michigan Avenue — Chicago 2, Illinois

1946 DIRECTORY *

"Jr." appearing in parenthesis following a name designates a junior physical therapy technician. A junior technician is a person with limited training in physical therapy but who has had a minimum of high school training and four years acceptable physical therapy experience. Registration in this class was closed Dec. 31, 1939. All others are senior physical therapy technicians. Only graduates of courses approved by the Council on Medical Education and Hospitals are eligible for application for registration. A list of these approved courses may be obtained by writing the American Medical Association, 535 North Dearborn Street, Chicago 10.

June 1, 1946. MARION G. SMITH, Registrar.

A

Abbott, A. Blanche, 1925 W. Venango St., Philadelphia, Pa.
Abel, Alice, Bushnell Gen. Hosp., Brigham City, Utah.
Ablen, Louise (See Myers).
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* See page 392 for supplement of names received too late to classify.

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Warren, Elizabeth (See Stoutamire).
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Warren, Winifred, Vets. Admin., Indianapolis, Ind.
Warsaw, Katharine (See Shockley).
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Whitlock, Eulia, High Springs, Fla.
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Wiechec, Kathryn, R. #4, Norristown, Pa.
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Young, Patience, 275 Beacon St., Boston, Mass.
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Yurek, Sophie (See Dineen).

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Hamlyn, Alvera, R. R. 1, Kankakee, Ill.
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(Continued on page 398)

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Name and Location of School	Medical Director	Technical Director	Entrance Requirements *	Duration of Course	Time of Admission	Maximum Enrollment	Tuition	Certificate, Diploma, Degree
Children's Hospital, Los Angeles[1]	Samuel Mathews, M.D.	Miss Lily Graham	a-b-c	14 mos.	Sept	14	$200	Diploma
College of Medical Evangelists, Los Angeles[1]	Fred B. Moor, M.D.	A. H. Carlson	a-b-c-d	12 mos.	Sept	20	$225	Cert. or Dipl.
University of California Hospital, San Francisco[1]	Frances Baker, M.D.	Miss Margery L. Wagner	a-b-c	12 mos.	MarchSept	10	$150	Certificate
Stanford University, Stanford University, Calif.[1]	W. H. Northway, M.D.	Miss Lucille Daniels	a-b-d	10 mos.	Quarterly	16	$409	Cert. or Degree
Northwestern University Medical School, Chicago	John S. Coulter, M.D.	Miss Gertrude Beard	a-b-d	12 mos.	JulyOct	16	$300	Certificate
State University of Iowa Medical School, Iowa City	W. D. Paul, M.D.	Miss Olive C. Farr	f	12 mos.	Sept	....	$200	**
University of Kansas School of Medicine, Kansas City[1]	G. M. Martin, M.D.	Miss Ruth G. Monteith	a-b-c[2]	10 mos.	FebSept	20	$ 50[3]	Cert. or Degree
Bouvé-Boston School of Physical Education, Boston	Arthur L. Watkins, M.D.	Miss Constance K. Greene	c[4]	10 mos.	Sept	15	$250[5]	Cert. or Degree
Harvard Medical School, Boston	James W. Sever, M.D.	Miss Janet B. Merrill	a-b-d	9 mos.	Varies	22	$300	Certificate
Boston University, College of Physical Education for Women, Sargent College, Cambridge, Mass.	Louis Howard M.D.	Miss Adelaide L. McGarrett	H.S.	4 yrs.	Sept	20	Varies	Cert. or Degree
University of Minnesota, Minneapolis[1]	M. E. Knapp, M.D.	Miss Sara Kollman	c	12 mos.	June	24	$200[3]	Certificate
Barnes Hospital, St. Louis	F. H. Ewerhardt, M.D.	Miss Beatrice F. Schulz	a-b-c	9 mos.	Oct	12	$200	Certificate
St. Louis University School of Nursing, St. Louis[1]	A. J. Kotkis, M.D.	Sister Mary Imelda	a[2]	10 mos.	Jan-Sept	12	$250 yr.	Cert. or Degree
Columbia University, College of Physicians and Surgeons, New York City[1]	William B. Snow, M.D.	Miss Josephine L. Rathbone	a-c[6]	2 yrs.	Sept	35	$400 yr.	Cert. or Degree
New York University School of Education New York City[1]	George G. Deaver, M.D.	Miss Elizabeth C. Addoms	a-b-c	9½ mos.	Sept	40	$525	Cert. & Degree
Duke Hospital, Durham, N. C.[1]	Lenox D. Baker, M.D.	Miss Helen Kaiser	a-b-c	12 mos.	Oct	12	$200	Certificate
D. T. Watson School of Physiotherapy, Leetsdale, Pa.[1]	Jessie Wright, M.D.	Miss Kathryn Kelley	a-b-d	12 mos.	Oct	30	$200	Dipl. or Degree
Graduate Hosp. of the Univ. of Pennsylvania, Phila.[1]	G. M. Piersol, M.D.	Miss K. Sutherland	a-b-c	12 mos.	Sept	20	$200	Certificate
University of Texas School of Medicine, Galveston[1]	G. W. N. Eggers, M.D.	Miss Ruby Decker	a-b-c	9 mos.	Jan	6	$110	Certificate
Baruch Center of Physical Medicine of the Medical College of Virginia, Richmond, in affiliation with Richmond Professional Institute[1]	F. A. Hellebrandt, M.D.	J. J. Buchanan, M.D.	a-b-c[2]	12 mos.†	Sept	20	$200[3]	Cert. or Degree
University of Wisconsin Medical School, Madison[1]	Elizabeth Grimm, M.D.	Miss Margaret A. Kohli	a-b-c[2]	12 mos.	Sept	20	$ 96[3]	Cert. or Degree

* Courses are so arranged that any of the entrance requirements will qualify students for training. a = Graduation from accredited school or nursing; b = Graduation from accredited school of physical education; c = Two years of college with science courses; d = Three years of college with science courses; e = Four years of College with science courses; H. S. = High school graduation; f = degree in physical education or sciences.

† Currently eighteen Navy nurses are enrolled in a six-month emergency course.

1. Male students admitted.
2. High school graduates admitted to four-year course leading to degree.
3. Non-residents charged additional fee.
4. High school graduates admitted to four-year course leading to degree from Tufts College.
5. Tuition for degree course is $400 per year.
6. College graduates admitted to twelve-month certificate course.

‡ Reprinted in part J. A. M. A. 130:1156 (April 20) 1946.

** At the end of nine months the students can register in the graduate school for a degree of master of science in Physical Therapy.

APPROVED SCHOOLS FOR OCCUPATIONAL THERAPY TECHNICIANS *

Council on Medical Education and Hospitals of the American Medical Association

NOTE: The duration of the course is expressed in academic years and in most schools the accelerated curriculum is being followed.

Name and Location of School	College Affiliation	Duration of Course	Classes Start	Entrance Requirements	Tuition Per Year	Certificate, Diploma, Degree	Graduates in 1945
University of Southern California, 3551 University Ave., Los Angeles	University of Southern California	2 yrs. 5 yrs.	Sept FebSept	Degree High sch.	$330 $330	Certificate Cert.&B.S.	8
Mills College, Oakland, Calif.	Mills College	3 yrs. 5 yrs.	FebSept FebSept	Degree High sch.	$200 $450	Certificate Cert.&Deg.	4
San Jose State College, San Jose, Calif.	San Jose State College	3 yrs. 5 yrs.	JanOct Varies	1 yr. coll. High sch.	$ 21 $ 21	Certificate Degree	1
University of Illinois College of Medicine, 1853 W. Polk St., Chicago	University of Illinois	4½ yrs.	Varies	High sch.	$ 80	B.S.	None
University of Kansas, Lawrence	University of Kansas	2 yrs. 4 yrs.	FebSept FebSept	Degree High sch.	$ 50 $ 50	Certificate B.S.	1
Boston School of Occupational Therapy, 7 Harcourt St., Boston	Tufts College	2 yrs. 3 yrs. 5 yrs.	Sept JulySept Sept	Degree 1 yr. coll. High sch.	$400 $400 $400	Diploma Diploma Dipl.&B.S.	41
Kalamazoo School of Occupational Therapy, Western Michigan College of Education, Kalamazoo	Western Michigan College of Education	2 yrs. 4 yrs.	July FebSept	Degree 1 yr. coll.	$ 51 $ 95	Certificate Cert.&Deg.	20
Michigan State Normal College, Ypsilanti	Michigan State Normal College and Univ. of Michigan	5 yrs.	Varies	High sch.	$ 67	Cert.&Deg.	8
St. Louis School of Occupational and Recreational Therapy, 4567 Scott Ave., St. Louis	Washington University	3 yrs.	Sept	2 yrs. coll.	$350	B.S.	13
University of New Hampshire, Durham	Univ. of New Hampshire	5 yrs.	Sept	High sch.	$160	Cert.&Deg.	5
Columbia University College of Physicians and Surgeons, 630 W. 168th St., New York City	Columbia University	2 yrs. 3 yrs.	Sept Sept	Degree 2 yrs. coll.	$450 $450	Certificate B.S.	18
New York University School of Education, 100 Washington Sq. E., New York City	New York University	4½ yrs.	Quarterly	High sch.	$450	Cert.&Deg.	13
Ohio State University, Columbus	Ohio State University	4½ yrs.	Quarterly	High sch.	$ 80	B.S.	11
Philadelphia School of Occupational Therapy, 419 S. 19th St., Philadelphia	University of Pennsylvania	2 yrs. 3 yrs. 5 yrs.	Sept Sept Varies	Degree 1 yr. coll. High sch.	$400 $400 $400	Diploma Diploma Dipl.&B.S.	45
Richmond Professional Institute, 901 W. Franklin St., Richmond, Va.	College of William and Mary	2½ yrs. 3 yrs.	Sept Sept	Degree 1 yr. coll.	$200 $200	Certificate Diploma	4
Milwaukee-Downer College, Dept. of Occupational Therapy, 2512 E. Hartford, Milwaukee	Milwaukee-Downer College	3 yrs. 5 yrs.	Sept Sept	1 yr. coll. High sch.	$250 $250	Diploma Dipl.&B.S.	15
Mount Mary College, 2900 Menomonee River Dr., Milwaukee	Mount Mary College	5 yrs.	Sept	High sch.	$210	B.S.	7
University of Toronto, Dept. of University Extension, Toronto, Ont., Canada	University of Toronto	3 yrs.	Sept	1 yr. coll.	$175	Diploma	40

* Reprinted J. A. M. A. 130:1155 (April 20) 1946.

HOTEL RATES

American Congress of Physical Medicine

September 3, 4, 5, 6, 7, 1946

Hotel Pennsylvania — **New York City**

Unless requested otherwise, we will hold your reservation until 9 p. m. of the day of your arrival.

Date Arriving	Hour	A. M. / P. M.
Room and Bath	3.85 ☐	5.50 ☐
for One	4.40 ☐	6.05 ☐
Per Day	4.95 ☐	6.60 ☐
		7.15 ☐
Double-Bed Room	5.50 ☐	7.70 ☐
with Bath	6.05 ☐	8.25 ☐
For Two—Per Day	6.60 ☐	8.80 ☐
Twin-Bed Room		7.70 ☐
with Bath	6.50 ☐	8.25 ☐
For Two—Per Day	7.15 ☐	8.80 ☐
SUITE—		11.00 ☐
Living Room,		
Bed Room and Bath	10.00 ☐	13.00 ☐

MORE THAN 2 PERSONS IN 1 ROOM
For each additional person in Double or Twin-Bed Room the extra charge is $2.00 per day.

If a room at the rate requested is unavailable, reservation will be made at the next rate.

Registry Directory

(*Continued from page 392*)

Smith, Virginia, 6942 Cresheim Rd., Philadelphia, Pa.
Suddath, Mary, Box 150, Groesbeck, Texas.
Sweeney, Mr. John, 149 Lincoln Ave., Paterson, N. J.
Thomas, Virginia, 1195 E. 34th St., Brooklyn, N. Y.
Thompson, Lois, 14 Washington St., Williamsport, Ind.
Valentine, Alice, 336 Washington St., Taunton, Mass.
Van Buskirk, Sarah, R. 2, Bath, Pa.
Van Cott, Barbara, 19 Haxton Pl., Salt Lake City, Utah.
Walk, Rae, Ramsey, Ind.
Walker, Mary, 1530 Paloma St., Pasadena, Calif.
Wall, Ruth, 517 W. 60th St., Los Angeles, Calif.
Waters, Ellen, 526 Melrose, N., Seattle, Wash.
Wenstrom, Hildegard, 908 Grand Ave., St. Paul, Minn.
Willer, R. Lorraine, R. 1, Marion, Mich.
Wilt, Iris, R. 2, P. O. Box 167, Aliquippa, Pa.
Wohlgemuth, Esther, 29 Oak Lane, Scarsdale, N. Y.
Wood, Evelyn, Barryton, Mich.
Wood, Marjorie, R. 1, Minot, N. D.
Woods, Gladys, 516 W. Main St., Norman, Okla.
Zimmerman, Ruth, 2370 N. 73d St., Milwaukee, Wis.
Zlomek, Helen, R. 2, Hudson, N. Y.

TENTATIVE PROGRAM

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION NATIONAL CONVENTION

CONGRESS HOTEL

Chicago Illinois, August 12, 13, 14, 1946

Monday, August 12

Business Meeting — Mr. E. S. Elwood, president, presiding.
General Meeting.
Mental Hygiene for Us.
Sectional Meetings — afternoon.
Psychiatry — Recreational Therapy.
Relation of Psychosomatic Medicine and Occupational Therapy.
General — Physical Medicine.
Tuberculosis, a Graded Program and Prevocational Aspects.
House of Delegate Meeting — evening.

* * * *

Tuesday, August 13

General Session — morning.
The Future of Occupational Therapy in the Army.
Sectional Meetings — Round Tables — morning.
Administration of an Occupational Therapy Department.
Workshops in Relation to Industrial Rehabilitation.
A Graded Program for Cardiacs.
Bibliography.
Occupational Therapy with the Paraplegia Patient.
Music Therapy.
Hospital Visits — afternoon.
Banquet — evening.
Board of Managers Meeting — evening.

* * * *

Wednesday, August 14

General Session — morning.
Rehabilitation in the Veterans Program.
Sectional Meetings — Round Tables — morning.
Clinical Training and the Student.
Industrial Therapy and Psychiatry.
A Scouting Program in the Hospital.
Drama Therapy.
A Graded Program for the Cerebral Palsy Patient.
School Luncheons.
Demonstrations — afternoon.
Special equipment and technics will be demonstrated by therapists.

MEETINGS OF INTEREST TO THOSE IN THE FIELD OF PHYSICAL MEDICINE

In these columns will be published information about meetings of interest to those in the field of physical medicine. New data should be sent promptly to the office of the Secretary, 2 E. 88th St., New York 28, N. Y.

American Congress of Physical Medicine, 24th Annual Session, Hotel Pennsylvania, New York, September 4, 5, 6 and 7, 1946; **Instruction Course** to be held during the meeting; Dr. Richard Kovács, 2 East 88th Street, New York 28, Secretary. See announcement elsewhere this issue.

Western Section, American Congress of Physical Medicine, San Francisco. Thursday, June 27th, Stanford University Hospital; Friday, June 28th, California Hospital. Dr. W. H. Northway, Stanford University Hospitals, Clay and Webster Streets, San Francisco 15, Calif., Secretary. See announcement elsewhere this issue.

New York Society of Physical Medicine; meetings on first Wednesday, from October to May, New York City; Dr. Madge C. L. McGuinness, 51 East 87th Street, New York 28, Secretary.

The Pennsylvania Academy of Physical Medicine; meetings at the Philadelphia County Medical Building, 21st and Spruce Streets. For 1946 schedule inquire of Secretary, Dr. Harold Lefkoe, 1824 Spruce Street, Philadelphia 3.

Southern California Society of Physical Medicine, Secretary-Treasurer, Dr. Clarence Dail, 802 Acacia Street, San Gabriel, Calif.

American Physiotherapy Association, Annual Conference, June 16 to 22, 1946, Blue Ridge, N. C. Mildred Elson, Executive Secretary, 1790 Broadway, New York 19, N. Y.

American Occupational Therapy Association, Congress Hotel, Chicago, August 11 to 15, 1946. Mrs. Meta R. Cobb, Executive Secretary, 33 West 42nd Street, New York 18, N. Y. See announcement elsewhere this issue.

INSTRUCTION COURSE

In Conjunction with the

24th Annual Scientific and Clinical Session

AMERICAN CONGRESS OF PHYSICAL MEDICINE

September 4, 5, 6, 7, 1946

HOTEL PENNSYLVANIA **NEW YORK, N. Y.**

	Wednesday September 4	Thursday September 5	Friday September 6
8 A.M. to 9 A.M.	(1) Peripheral Nerve Injuries (Physiologic Studies) Hines (2) Anatomical Reasons for Foot Strain (Treatment) Frances Baker	(7) Physiologic Basis for Therapeutic Exercise F. Hellebrandt (8) Fundamentals of Electricity as Applied to Physical Medicine Lion	(13) Rehabilitation of Industrial Injured Aitken (14) Tests and Measurements (Joints; Strength Tests) Molander
9 A.M. to 10 A.M.	(3) Pain (Types: Neurotic, Radiating or Referred, Causalgic, Ischemic) Harpuder (4) Low Back Pain (Anatomical and Mechanical Basis) Jessie Wright	(9) Reconditioning in Certain Medical and Surgical Conditions (Cardiacs, Chest Surgery) Huddleston (10) Prescription Writing in Physical Medicine Martin	(15) Electrical Stimulation of Denervated Muscle (With Actual Demonstration on a Model) Osborne (16) Use of Physical Therapy Following Various Fractures of the Extremities Knapp
1 P.M. to 2 P.M.	(5) Functional Anatomy of the Shoulder Girdle Quiring (6) Functional Anatomy of the Hand Marble	(11) Essentials of Muscle Reeducation Bennett (12) Lecture and/or Demonstration (Crutch Walking) Deaver	(17) Rehabilitation of the Severely Disabled Deaver (18) Hydrotherapy and Spas (Present Status) Behrend

The course is intended primarily for physicians but a limited number of the members of the American Registry of Physical Therapy Technicians will also be admitted. One or more lectures may be taken, but nine lectures comprise a full schedule. The charge for single lectures is $2.00; for the full schedule of nine lectures $15.00.

For information and application form address

AMERICAN CONGRESS OF PHYSICAL MEDICINE

30 North Michigan Avenue **Chicago 2**

APPROVED SCHOOLS FOR PHYSICAL THERAPY TECHNICIANS ‡

Council on Medical Education and Hospitals of the American Medical Association

Name and Location of School	Medical Director	Technical Director	Entrance Requirements *	Duration of Course	Time of Admission	Maximum Enrollment	Tuition	Certificate, Diploma, Degree
Children's Hospital, Los Angeles[1]	Samuel Mathews, M.D.	Miss Lily Graham	a-b-c	14 mos.	Sept	14	$200	Diploma
College of Medical Evangelists, Los Angeles[1]	Fred B. Moor, M.D.	A. H. Carlson	a-b-c-d	12 mos.	Sept	20	$225	Cert. or Dipl.
University of California Hospital, San Francisco[1]	Frances Baker, M.D.	Miss Margery L. Wagner	a-b-c	12 mos.	MarchSept	10	$150	Certificate
Stanford University, Stanford University, Calif.[1]	W. H. Northway, M.D.	Miss Lucille Daniels	a-b-d	10 mos.	Quarterly	16	$409	Cert. or Degree
Northwestern University Medical School, Chicago	John S. Coulter, M.D.	Miss Gertrude Beard	a-b-d	12 mos.	JulyOct	16	$300	Certificate
State University of Iowa Medical School, Iowa City	W. D. Paul, M.D.	Miss Olive C. Farr	f	12 mos.	Sept	....	$200	**
University of Kansas School of Medicine, Kansas City[1]	G. M. Martin, M.D.	Miss Ruth G. Monteith	a-b-c[2]	10 mos.	FebSept	20	$ 50[3]	Cert. or Degree
Bouvé-Boston School of Physical Education, Boston	Arthur L. Watkins, M.D.	Miss Constance K. Greene	c[4]	10 mos.	Sept	15	$250[5]	Cert. or Degree
Harvard Medical School, Boston	James W. Sever, M.D.	Miss Janet B. Merrill	a-b-d	9 mos.	Varies	22	$300	Certificate
Boston University, College of Physical Education for Women, Sargent College, Cambridge, Mass.	Louis Howard M.D.	Miss Adelaide L. McGarrett	H.S.	4 yrs.	Sept	20	Varies	Cert. or Degree
University of Minnesota, Minneapolis[1]	M. E. Knapp, M.D.	Miss Ruby Green	c	12 mos.	June	24	$200[3]	Certificate
Barnes Hospital, St. Louis	F. H. Ewerhardt, M.D.	Miss Beatrice F. Schulz	a-b-c	9 mos.	Oct	12	$200	Certificate
St. Louis University School of Nursing, St. Louis[1]	A. J. Kotkis, M.D.	Sister Mary Imelda	a[2]	10 mos.	Jan-Sept	12	$250 yr.	Cert. or Degree
Columbia University, College of Physicians and Surgeons, New York City[1]	William B. Snow, M.D.	Miss Josephine L. Rathbone	a-c[6]	2 yrs.	Sept	35	$400 yr.	Cert. or Degree
New York University School of Education New York City[1]	George G. Deaver, M.D.	Miss Elizabeth C. Addoms	a-b-c	9½ mos.	Sept	40	$525	Cert. & Degree
Duke Hospital, Durham, N. C.[1]	Lenox D. Baker, M.D.	Miss Helen Kaiser	a-b-d	12 mos.	Oct	12	$200	Certificate
D. T. Watson School of Physiotherapy, Leetsdale, Pa.[1]	Jessie Wright, M.D.	Miss Kathryn Kelley	a-b-d	12 mos.	Oct	30	$200	Dipl. or Degree
Graduate Hosp. of the Univ. of Pennsylvania, Phila.[1]	G. M. Piersol, M.D.	Miss K. Sutherland	a-b-c	12 mos.	Sept	20	$200	Certificate
University of Texas School of Medicine, Galveston[1]	G. W. N. Eggers, M.D.	Miss Ruby Decker	a-b-c	9 mos.	Jan	6	$110	Certificate
Baruch Center of Physical Medicine of the Medical College of Virginia, Richmond, in affiliation with Richmond Professional Institute[1]	F. A. Hellebrandt, M.D.	J. J. Buchanan, M.D.	a-b-c[2]	12 mos.†	Sept	20	$200[3]	Cert. or Degree
University of Wisconsin Medical School, Madison[1]	Elizabeth Grimm, M.D.	Miss Margaret A. Kohli	a-b-c[2]	12 mos.	Sept	20	$ 96[3]	Cert. or Degree

* Courses are so arranged that any of the entrance requirements will qualify students for training. a = Graduation from accredited school or nursing; b = Graduation from accredited school of physical education; c = Two years of college with science courses; d = Three years of college with science courses; e = Four years of College with science courses; H. S. = High school graduation; f = degree in physical education or sciences.

† Currently eighteen Navy nurses are enrolled in a six-month emergency course.

1. Male students admitted.
2. High school graduates admitted to four-year course leading to degree.
3. Non-residents charged additional fee.
4. High school graduates admitted to four-year course leading to degree from Tufts College.
5. Tuition for degree course is $400 per year.
6. College graduates admitted to twelve-month certificate course.

‡ Reprinted in part J. A. M. A. **130**:1156 (April 20) 1946.

** At the end of nine months the students can register in the graduate school for a degree of master of science in Physical Therapy.

APPROVED SCHOOLS FOR OCCUPATIONAL THERAPY TECHNICIANS *

Council on Medical Education and Hospitals of the American Medical Association

NOTE: The duration of the course is expressed in academic years and in most schools the accelerated curriculum is being followed.

Name and Location of School	College Affiliation	Duration of Course	Classes Start	Entrance Requirements	Tuition Per Year	Certificate, Diploma, Degree	Graduates in 1945
University of Southern California, 3551 University Ave., Los Angeles	University of Southern California	2 yrs.	Sept	Degree	$330	Certificate	8
		5 yrs.	FebSept	High sch.	$330	Cert.&B.S.	
Mills College, Oakland, Calif.	Mills College	3 yrs.	FebSept	Degree	$200	Certificate	4
		5 yrs.	FebSept	High sch.	$450	Cert.&Deg.	
San Jose State College, San Jose, Calif.	San Jose State College	3 yrs.	JanOct	1 yr. coll.	$ 21	Certificate	1
		5 yrs.	Varies	High sch.	$ 21	Degree	
University of Illinois College of Medicine, 1853 W. Polk St., Chicago	University of Illinois	4½ yrs.	Varies	High sch.	$ 80	B.S.	None
University of Kansas, Lawrence	University of Kansas	2 yrs.	FebSept	Degree	$ 50	Certificate	1
		4 yrs.	FebSept	High sch.	$ 50	B.S.	
Boston School of Occupational Therapy, 7 Harcourt St., Boston	Tufts College	2 yrs.	Sept	Degree	$400	Diploma	41
		3 yrs.	JulySept	1 yr. coll.	$400	Diploma	
		5 yrs.	Sept	High sch.	$400	Dipl.&B.S.	
Kalamazoo School of Occupational Therapy, Western Michigan College of Education, Kalamazoo	Western Michigan College of Education	2 yrs.	July	Degree	$ 51	Certificate	20
		4 yrs.	FebSept	1 yr. coll.	$ 95	Cert.&Deg.	
Michigan State Normal College, Ypsilanti	Michigan State Normal College and Univ. of Michigan	5 yrs.	Varies	High sch.	$ 67	Cert.&Deg.	8
St. Louis School of Occupational and Recreational Therapy, 4567 Scott Ave., St. Louis	Washington University	3 yrs.	Sept	2 yrs. coll.	$350	B.S.	13
University of New Hampshire, Durham	Univ. of New Hampshire	5 yrs.	Sept	High sch.	$160	Cert.&Deg.	5
Columbia University College of Physicians and Surgeons, 630 W. 168th St., New York City	Columbia University	2 yrs.	Sept	Degree	$450	Certificate	18
		3 yrs.	Sept	2 yrs. coll.	$450	B.S.	
New York University School of Education, 100 Washington Sq. E., New York City	New York University	4½ yrs.	Quarterly	High sch.	$450	Cert.&Deg.	13
Ohio State University, Columbus	Ohio State University	4½ yrs.	Quarterly	High sch.	$ 80	B.S.	11
Philadelphia School of Occupational Therapy, 419 S. 19th St., Philadelphia	University of Pennsylvania	2 yrs.	Sept	Degree	$400	Diploma	45
		3 yrs.	Sept	1 yr. coll.	$400	Diploma	
		5 yrs.	Varies	High sch.	$400	Dipl.&B.S.	
Richmond Professional Institute, 901 W. Franklin St., Richmond, Va.	College of William and Mary	2½ yrs.	Sept	Degree	$200	Certificate	4
		3 yrs.	Sept	1 yr. coll.	$200	Diploma	
Milwaukee-Downer College, Dept. of Occupational Therapy, 2512 E. Hartford, Milwaukee	Milwaukee-Downer College	3 yrs.	Sept	1 yr. coll.	$250	Diploma	15
		5 yrs.	Sept	High sch.	$250	Dipl.&B.S.	
Mount Mary College, 2900 Menomonee River Dr., Milwaukee	Mount Mary College	5 yrs.	Sept	High sch.	$210	B.S.	7
University of Toronto, Dept. of University Extension, Toronto, Ont., Canada	University of Toronto	3 yrs.	Sept	1 yr. coll.	$175	Diploma	40

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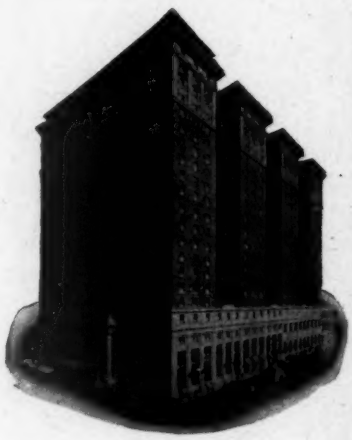
AMERICAN CONGRESS OF PHYSICAL MEDICINE

24th ANNUAL
SCIENTIFIC and CLINICAL SESSION

September
4, 5, 6, 7
1946

Hotel Pennsylvania
New York,
N. Y.



Physical Medicine is important in medical care. A general program with important advances made in this field will be presented. Make plans now to attend this meeting. Watch for announcement of program in the ARCHIVES.

An instruction course in the basic and clinical subjects of physical medicine will again be offered at this session. Visits to various departments of physical medicine in New York City will be scheduled for Saturday, Sept. 7.

EXECUTIVE OFFICES 30 NORTH MICHIGAN AVENUE CHICAGO 2, ILLINOIS